Division of Health Care Finance and Policy

The Impact of Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers and Medicaid

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A Report to the Senate Committee on Ways and Means, House Committee on Ways and Means and Joint Committee on Health Care

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The Impact of Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers and Medicaid

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Executive Summary

The Balanced Budget Act of 1997 (P.L. 105-33) was signed into law on August 5, 1997. As its name implies, the legislation was intended to bring the government substantially closer to its bipartisan goal of a balanced federal budget. The largest share of responsibility for accomplishing that goal was handed to Medicare. In fact, nearly three-quarters of the projected total savings of $525 billion over the next decade is to be achieved through reductions in Medicare program spending.[1] Through sweeping changes in the way in which Medicare contracts with providers, consumers and managed care organizations, an estimated $112 billion over the five budgetary years covered by the federal legislation (1998 through 2002), and $393 billion over the next ten, are to be cut from Medicare program outlays. As a result of the new law, the average annual rate of growth in Medicare expenditures is expected to decline from the current 8.5% to about 6% in 2007.

The most significant savings in Medicare's 32-year history are to be achieved in three basic ways: reductions in payment to providers, reductions in payment to insurers, and increases in contributions from beneficiaries. Over two-thirds of total Medicare program savings in the next five years will be accomplished by limiting growth rates in payments to general short term acute care hospitals. Another important source of savings comes from reductions in the rate of payment to hospital outpatient departments, chronic and rehabilitation facilities, skilled nursing facilities and home health care agencies. An additional 19% of savings comes from reductions in payment to Medicare managed care plans. Finally, an estimated 8% of savings stems from increases in the contributions of Medicare beneficiaries in the form of higher co-payments and premiums. Payment reductions are expected to be similarly distributed across provider categories and managed care plans in Massachusetts.

Massachusetts General Law Chapter 170, Section 37 of the Acts of 1997 required the Division of Health Care Finance and Policy (DHCFP) to analyze "the impact of changes in the Medicare Program contained in the Balanced Budget Act of 1997 as it affects Massachusetts health care providers and Medicare beneficiaries." In response, this report examines the potential effects of the Medicare provisions of the BBA as they relate to general, short-term acute care hospitals; chronic, rehabilitation and specialty hospitals; skilled nursing facilities; home health care agencies and managed care plans. Special attention is also given to assessing the BBA's impact on Medicaid. A brief discussion of the effect of the repeal of the Boren Amendment is included at the end. Where the data and provisions allow, an effort has been made to quantify the projected impact of the new legislation on providers and consumers in the state. Otherwise, a general discussion of the likely effects is provided. A brief summary of each of the individual sections in the report is highlighted below. More detailed information about each of these issues can be found in the appropriate section of the report that follows this executive summary.

Acute Care Hospitals

The Medicare provisions of the Balanced Budget Act (BBA) affect general short term acute care hospitals in two ways.[2] First, they reduce payment rates for inpatient services. The federal legislation freezes the annual update for the first year (1998) and provides for a slower rate of growth than previously mandated for the subsequent four years. In addition, they lower payment adjustments for such factors as indirect medical education, disproportionate share of indigent patients, capital expenditures and enrollee bad debt (uncollected co-payments). Payment rates for inpatient services are expected to decline by 1.7% in 1998, compared with a projected 4.4% increase under previously existing law (relative to the 1997 payment level). After 1998, payment rates begin climbing again, reaching an annual growth rate of 2.6% in 2002. The BBA is predicted to reduce Medicare payment to the Massachusetts PPS hospital sector as a whole by $1.4 billion over the next five years, 10% less than projected revenues of $12.9 billion under previous draft regulations.

For the acute care industry as a whole, the Medicare profit margin (the difference between revenue and cost divided by revenue) is projected to decline from 14.4% in 2002 under the old payment regulations to -0.1% under the BBA. The profit margin over all payers will subsequently fall from an estimated 9.9% to 2.3%. The ability of hospitals to absorb these rate reductions will depend largely on their current level of profitability. Large urban teaching hospitals, for instance, reported earning a total profit margin of 6.1% in 1997. Reflecting their financial strength, total profit margins in 2002 are expected to decrease from 11.3% without the BBA to 3.2% under the BBA. In contrast, small community hospitals reported incurring overall losses of 5.3% in 1997. With the implementation of the BBA, the profit margin of these facilities in five years time is predicted to fall from 1.9% to -4.9%. The analysis presented in Section A of this report suggests that, because of their current financial problems, small community hospitals will be least able to absorb the rate reductions mandated by the BBA, with important implications for access and quality.

The second effect of the BBA on acute care facilities has to do with the reimbursement of hospital outpatient services. Under the federal legislation, Medicare is mandated to develop and implement a prospective payment system (PPS) for outpatient services by January 1999. While details of the outpatient PPS have not yet been finalized, it will be based on the Ambulatory Payment Classification (APC) system. Under this system, all patients are categorized into one of 300 APCs based on procedures, visits and ancillary services, with each APC carrying a specific price. Unlike for inpatient PPS, however, hospitals can receive payment for a given patient for more than one APC at a time. Low cost providers will benefit from the system and high cost providers will lose. Key features in determining the amount of risk each hospital will bear are: (1) definition of a visit; (2) packaging of ancillary services into APCs; (3) discounting and consolidation of procedures; (4) calculation of payment weights; and (5) adjustments for outliers. Medicaid began implementation of its own outpatient PPS last year. Lessons learned from its experience should provide a sense of the impact of APCs on hospitals and patients.

Excluded Hospitals

The complexity of Medicare reimbursement to PPS-excluded facilities is largely due to the heterogeneity among hospitals as well as the range of patients they serve. While we are able to show average Medicare payments and cost per discharge for this sector of the health care industry, the considerable variation from facility to facility in Massachusetts must be emphasized. Children's Hospital and the Dana Faber Cancer Institute will largely remain unaffected by BBA changes and are not subject to the target caps. [3]

The already intricate system under the BBA will increase in complexity with new thresholds for differential updates, an additional incentive mechanism, new opportunities to re-base, limits on capital pass through and caps on operating cost TEFRA targets.[4] The phase-in of the prospective case-mix payment system for rehabilitation hospitals and units, beginning in 2000 and to be fully implemented in 2002, will resolve many of the issues concerning payment equity for these facilities. In Massachusetts, it is possible that Medicare reform will affect two thirds of hospital TEFRA payments by the turn of the century.

Nursing Facilities

As with other sectors, the BBA mandates that the Health Care Financing Administration submit to Congress by May 1, 1998 a proposal for implementing a prospective payment system for reimbursing the nursing facility industry. Although the exact financial impact of the BBA on Massachusetts nursing facilities remains unclear, there are a number anticipated issues that should be monitored closely. First, nursing facility administrators may decide to eliminate or reduce some ancillary services to Medicare patients, such as laboratory services or clinical social work services. The type of Medicare patients being admitted to nursing facilities should be monitored to ensure that certain type of patients, such as patients with cognitive and behavioral problems, are still receiving adequate access and quality of care. Whether changes in service patterns occur is contingent on the incentives provided by the prospective payment system.

Second, some nursing facilities will have a difficult transition to consolidated billing. This may result in payment delays for ancillary providers and additional administrative costs for nursing facilities. Third, hospital based transitional care units will be most vulnerable to Medicare payment reductions. It is possible that a number of these facilities will close or convert to other uses. Smaller, not-for-profit, nursing facilities will also be more vulnerable to the changes implemented under BBA. Finally, while Medicare utilization in nursing facilities will likely remain stable or perhaps even decline as a result of the BBA-mandated reductions in home health care payments, Medicaid utilization in nursing facilities may increase.

Home Health Services

The Balanced Budget Act of 1997 has four main provisions for home health care. It provides an Interim Payment System for the period October 1, 1997 to September 30, 1999; requires that a Prospective Payment System be implemented October 1, 1999;

transfers part of the home health benefit to Medicare Part B; and requires every home health agency to secure surety bonds in order to participate in the Medicare and Medicaid programs. These provisions will increase liability risks for agencies under the new system of restricted payment. Agencies will also be faced with additional administrative costs. The small, non-profit, and rural agencies are more likely to feel the impact of BBA than others. Overall, we estimate the impact of the interim payment system change on Massachusetts' providers to be almost $111 million a year. Agencies may choose not to care for certain high cost and high acuity patients. This may result in a large number of chronically ill patients being admitted to long term care facilities at significantly greater cost to both the Medicare and Medicaid programs.

Managed Care

There are three important changes in the BBA that will effect Medicare's managed care program. First, there will be an increase in the number of options available to Medicare beneficiaries as a result of the BBA. Second, Medicare has been directed to introduce a capitation methodology that takes into account variation in severity of illness among enrollees and average national costs. Third, Medicare has been directed to gather encounter data from managed care plans in order to be able to monitor plan performance more effectively.

The BBA introduces several new types of plans that Medicare beneficiaries may choose instead of the traditional program. Together, these plans are referred to as the Medicare + Choice Program. Under the Medicare + Choice Program, beneficiaries may enroll in four basic types of plans. These include 1) Coordinated Care Plans; 2) Medical Savings Accounts (MSA's); 3) Private Fee-For-Service Plans; and 4) Religious Fraternal Benefit Society Plans. It is unclear how desirable these different plans will be, or their precise impact on providers, consumers and Medicaid.

Repeal of the Boren Amendment

As part of the Balanced Budget Act of 1997, Congress repealed the so-called Boren Amendment. This amendment, enacted in 1981, required states to pay hospitals, nursing facilities and intermediate care facilities for the mentally retarded, at Medicaid rates that were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." A number of state reimbursement systems were challenged under this provision, and some courts found that state systems did not meet the Boren standard.

The Balanced Budget Act repealed the Boren Amendment and established a public notice process for proposed rates and rate methodologies. States must now publish in advance a description and justification of any proposed change in rate methodology, as well as the proposed rates. These are subject to public review and comment before adoption.

The repeal of the Boren Amendment is likely to have little effect on the Medicaid rates paid by the states, including the Commonwealth of Massachusetts. In addition, current Massachusetts state law imposes a standard similar to Boren in determining

certain Medicaid rates of payment. M.G.L. c.118G requires the Division of Health Care Finance and Policy to "impose such methods and standards as are necessary to ensure reimbursement for those costs which must be incurred by efficiently and economically operated facilities and providers."

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[1] The national figures cited in this section are taken from Marilyn Moon, Barbara Gage and Alison Evans' *An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997*, The Urban Institute, September 1997. Another useful source of national-level data cited elsewhere in this report is *Report to the Congress: Medicare Payment Policy*, Volumes I and II by the Medicare Payment Advisory Commission, March 1998, Washington, DC.

[2] The term 'general short term acute care hospital' is generally meant to distinguish the hospital from specialty or long-term care facilities. The American Hospital Association defines a short term hospital as one in which the average length of stay is less than 30 days.

[3] 42 C.F.R. § 412.23(f). Legislative mandate provided that all additional cancer hospitals be classified as excluded by 12/31/91.

[4] The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established the reimbursement guidelines for PPS-excluded hospitals. A description of the system is provided in Section B.

Chapter 1: Introduction

The federal Balanced Budget Act (BBA) of 1997 (P.L. 105-33) makes major changes in almost every aspect of the Medicare program. (A brief summary of Medicare eligibility requirements and benefits is provided in Appendix A.) It reduces Medicare program spending by an estimated $112 billion relative to baseline projections between fiscal years 1998 and 2002.[1] Almost one half of the projected savings are realized through reduced growth in payments to hospitals. Most of the rest of the savings comes from reduced growth in payments to managed care plans (19%), home health and skilled nursing facilities (24%) and individual physicians (5%), as well as from reduced growth in payment for durable medical equipment (4%). The BBA is predicted to achieve a total Medicare program savings of between $400 and $450 billion over the next ten years.

The BBA also reduces the growth of federal Medicaid program spending by an estimated $13 billion over the next five budget years encompassed by the new legislation and $61 billion over the next ten years.[2] After accounting for off-setting increases in federal Medicaid expenditures from such programs as the State Children's Health Insurance Program, the BBA is estimated to achieve a net reduction in federal Medicaid outlays of $7.3 billion over the next five years and $36.9 billion over the next ten years.

In order to implement long-term savings in the Part A Medicare Trust Fund, the new legislation substantially restructures the Medicare program in several ways. First, it alters the way in which Medicare reimburses providers. The BBA lowers the rate of payment under the current prospective payment system (PPS) used to reimburse non-specialty acute care hospitals and authorizes the development or implementation of new prospective payment systems for skilled nursing facilities (by July 1998), hospital outpatient departments (by January 1999), long-term care hospitals and home health agencies (by October 1999) and rehabilitation facilities (by October 2000). Under the provisions of the BBA, Medicare should complete the switch from cost or charge-based reimbursement to prospective payment within the next few years, a process first initiated among acute care facilities in 1983.

Second, the BBA contains important changes in the way in which Medicare does business with managed care organizations as well. The new legislation fully embraces managed care as an alternative means of providing health care to its beneficiaries (older Americans and people with disabilities). In addition to the traditional options available to Medicare-eligible individuals (fee-for-service plans or risk-contracting plans with managed care organizations), the new Medicare+Choice program initiated by the BBA will additionally allow for provider sponsored organizations, private fee-for-service plans, and a demonstration of medical savings account.[3] Some critics of the new legislation argue that these changes represent the transformation of Medicare from a benefit program in which all individuals receive a fixed health benefit to a contribution program in which beneficiaries receive a set amount of money to purchase health insurance through a variety of delivery models. The extent to which consumers will take advantage of these additional choices remains to be seen.

In response to Massachusetts General Law Chapter 170, Section 37 of the Acts of 1997, the purpose of this report is to outline the Medicare provisions of the BBA and assess their impact on providers and consumers of health care services in Massachusetts over the next five years. This report is organized in the following way. Section A addresses reforms relating to non-specialty acute care hospitals reimbursed under PPS. Section B discusses the provisions of the law dealing with the non-acute hospitals and units exempted from PPS. The impact of the BBA on the nursing facility and home health industries is addressed in Sections C and D, respectively. Section E reviews the provisions of the federal legislation relating to managed care. Finally, a brief assessment of the impact of the repeal of the Boren Amendment on Massachusetts providers is presented in Section F. Where applicable, each section describes the current status of the industry in Massachusetts; explains the previous Medicare reimbursement guidelines; details the changes mandated by the BBA; and assesses the potential impact on providers and consumers. Included is a special effort to assess the implications of the BBA for the Medicaid program. Where legislative changes and availability of data permit, an effort is made to quantify the impact of the new laws. Where the BBA calls for the development of a new system or where data are not available, a general discussion of the likely effects is provided.

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[1] Medicare accounted for approximately 11% of total government outlays in 1995, making it an obvious target of efforts to reduce the federal deficit. Prior to the enactment of the BBA, Medicare expenditures were expected to grow at an annual rate of between 8% and 9%. Under the new legislation, the growth rate was reduced to 6%, only one percentage point above the nominal increase in the gross domestic product (GDP).

[2] Estimates of Medicare and Medicaid program savings at the national level are taken from the *Report to Congress: Medicare Payment Policy*, Vols. I and II, by the Medicare Payment Advisory Commission, March 1998.

[3] In 1997, 14% of all Medicare beneficiaries were enrolled in managed care plans, compared with only 3% enrolled in 1990.

Chapter 2: Medicare Reforms

Section A: Acute Care Hospitals

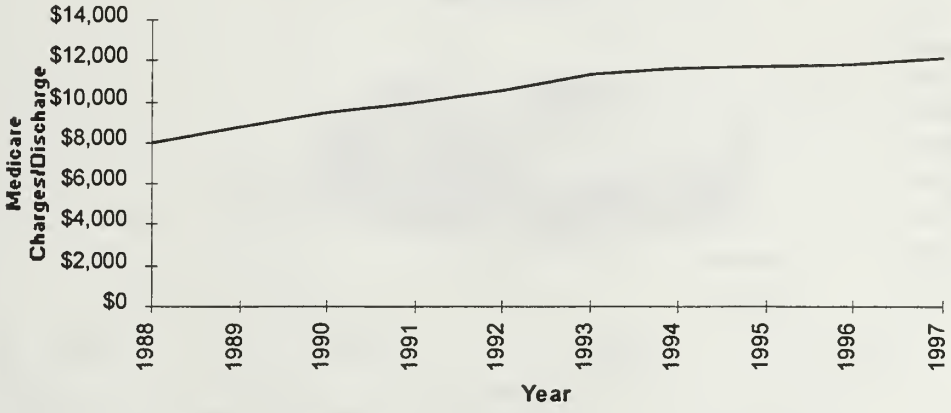
This section examines the potential impact of the Medicare provisions in the Balanced Budget Act of 1997 (BBA) on hospitals in Massachusetts paid under the federal Prospective Payment System. The Prospective Payment System (PPS) is used to reimburse short-term, non-specialty, acute care facilities for services provided to Medicare-eligible individuals. The treatment of Medicare beneficiaries at chronic care and rehabilitation facilities and units within acute care hospitals, as well as at specialty care hospitals (such as Children's Hospital and the Dana Farber Cancer Institute) are exempted from PPS. The effects of the Medicare provisions in the BBA on PPS-exempt hospitals and units are discussed in Section B of this report.[1]

1. Status of the Industry in Massachusetts

There are at present 85 hospitals in Massachusetts that are reimbursed under PPS.[2] They range from large, teaching facilities such as the Massachusetts General Hospital with over 800 beds and approximately 17,000 Medicare-funded discharges annually to small community-based hospitals like Nantucket Cottage Hospital with approximately 20 beds and 300 Medicare-funded discharges. As this discussion attempts to make clear, the impact of the Medicare provisions in the BBA will depend largely on the existing financial performance of each individual facility which, in turn, appears to be highly correlated with such hospital characteristics as teaching affiliation, share of indigent admissions, and size, measured in terms of number of beds.

PPS payments represent the largest single component of Medicare expenditures. Nationally, roughly one-third of all Medicare expenditures in 1995 were for inpatient services at PPS hospitals. The bulk of the anticipated savings in the BBA also comes from reductions in PPS payments. Over the next five budget years, approximately $32 billion of savings (out of a projected total Medicare program savings of $112 billion) are achieved through reductions in payments to PPS hospitals. In Massachusetts, Medicare spent over $2.3 billion for inpatient services at PPS hospitals in 1996 (out of a total estimated inpatient revenue of $4.4 billion). The Medicare provisions in the BBA are expected to reduce inpatient service revenue to Massachusetts PPS hospitals by $1.4 billion over the next five years. This represents an estimated decline of over 10% in the amount of Medicare inpatient revenue PPS hospitals in Massachusetts would have received under previous reimbursement regulations. Since Medicare is the single largest payer of hospital services, reductions in revenues of this magnitude carry serious implications for the financial status of PPS hospitals.

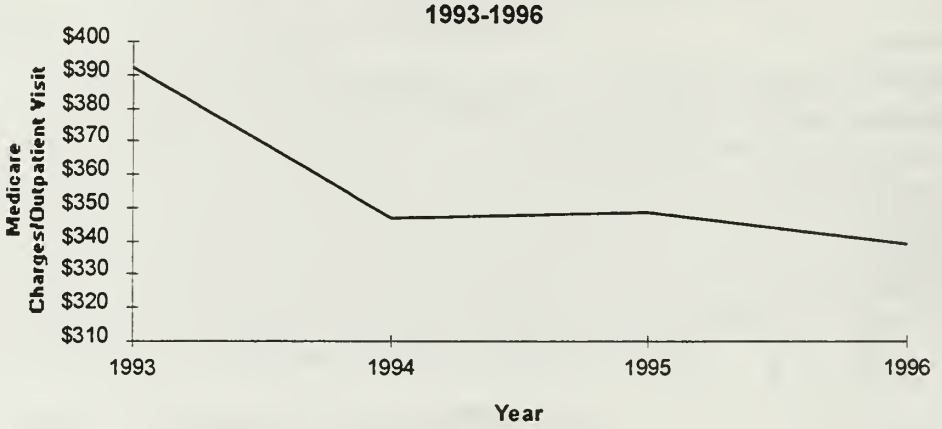
Figure 1
Massachusetts Acute Care Hospital Charges
Per Medicare-Funded Inpatient Discharge:
1988-1997



Source: *Division of Health Care Finance and Policy*

To place the legislated cutbacks in an historic context, information presented in Figure 1 above suggests that per patient Medicare *charges* from PPS hospitals in Massachusetts have actually declined *in real terms* over the past four years. (Actual revenue data for years other than 1996 were not attainable for this analysis.) While PPS per patient charges have increased nearly 50% over the past decade, almost all of the growth occurred in the 1980s and early 1990s. The average annual rate of growth in Medicare charges per discharge between 1988 and 1993 was 7.3%, compared with an annual average increase in hospital input prices of 4.2%.[3] In sharp contrast, Medicare charges since 1993 have increased on average only 1.3% per annum, compared to a 2.8% annual growth rate in PPS input prices.[4] Moreover, as depicted in Figure 2 below, average Medicare charges per outpatient visit have declined even in nominal terms over the past four years, from $392 in 1993 to $339 in 1996. The BBA cutbacks in PPS payments will further erode hospital profits in Massachusetts in real terms even with continued declines in hospital cost inflation.

Figure 2
Massachusetts Acute Care Hospital Charges
Per Medicare-Funded Outpatient Visit:
1993-1996



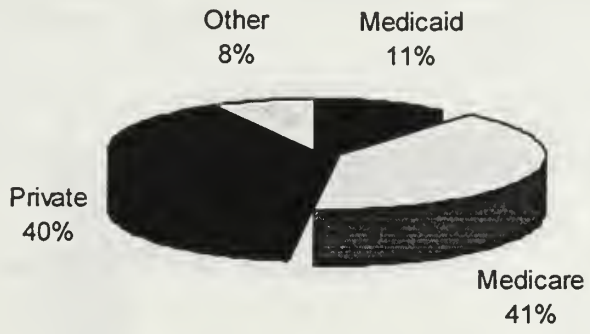
Source: *Division of Health Care Finance and Policy*

2. Current Reimbursement Strategies

a. Medicare Utilization of Acute Care Hospital Services

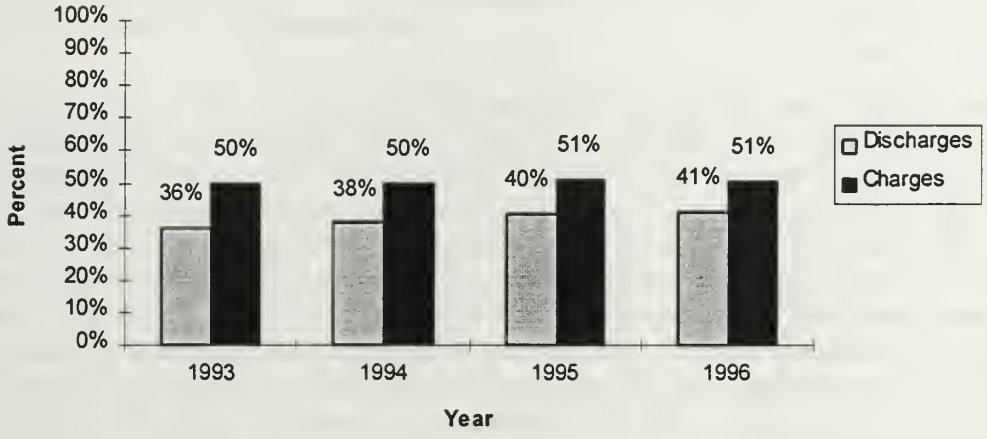
Medicare is by far the single largest payer of hospital services, both nationally and in Massachusetts. The hospital discharge data presented in Figure 3 below indicate that Medicare currently pays for over 40% of all PPS hospital admissions in the state. (In contrast, Medicaid pays for 11%, while most of the remaining discharges are covered by private insurers or are uninsured.) As the share of the elderly in the state's population continues to rise, the steady growth in the proportion of PPS hospital admissions covered by Medicare evidenced in Figure 4 below is likely to continue. Moreover, given the greater medical needs of individuals covered by Medicare (all elderly and the permanently disabled non-elderly), the share of total inpatient service charges accounted for by the federal payer is even higher than its share of admissions. Information exhibited in Figure 4 further reveals that over 50% of all inpatient service charges are attributable to Medicare. Since, unlike most other payers, Medicare reimburses hospitals for a portion of enrollee bad debt (uncollected co-payments), this probably understates its share of total revenue.

Figure 3
Share of Massachusetts Hospital Discharges by Payer: *1996*



Source: *Division of Health Care Finance and Policy*

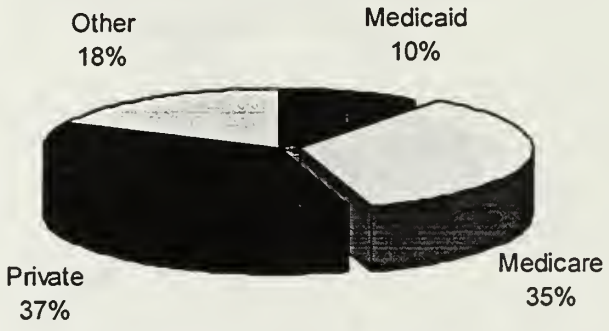
Figure 4
Medicare Inpatient Utilization:
Medicare Discharges and Charges as Percent of Totals
1993-1996



Source: *Division of Health Care Finance and Policy*

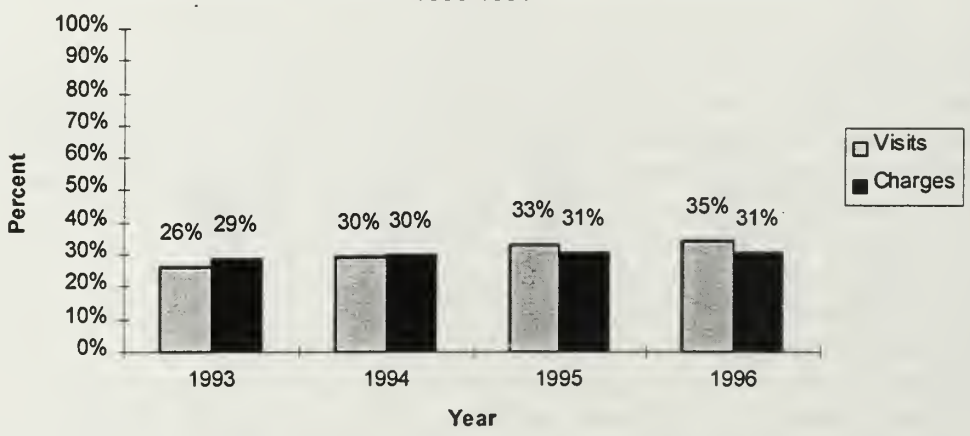
The importance of Medicare as a payer of outpatient services at PPS hospitals is slightly less than for inpatient services. In 1996, Medicare paid for approximately 35% of all outpatient claims, while Medicaid paid for 10%. (See Figure 5 below.) But Medicare's relative contribution in terms of coverage is rising at a faster rate. As Figure 6 below illustrates, the proportion of outpatient visits covered by Medicare has increased by more than 30% over the past four years, from 26% in 1993 to 35% in 1996 . Finally, as information presented in Figure 6 further illustrates, the share of outpatient service charges attributable to Medicare is slightly less than its share of visits, suggesting that Medicare beneficiaries are on average less costly to treat than outpatient visits covered by other payers.[5]

Figure 5
Share of Massachusetts Hospital Outpatient Visits by Payer:
1996



Source: *Division of Health Care Finance and Policy*

Figure 6
Medicare Outpatient Utilization:
Medicare Outpatient Visits and Charges as Percent of Totals
1993-1996



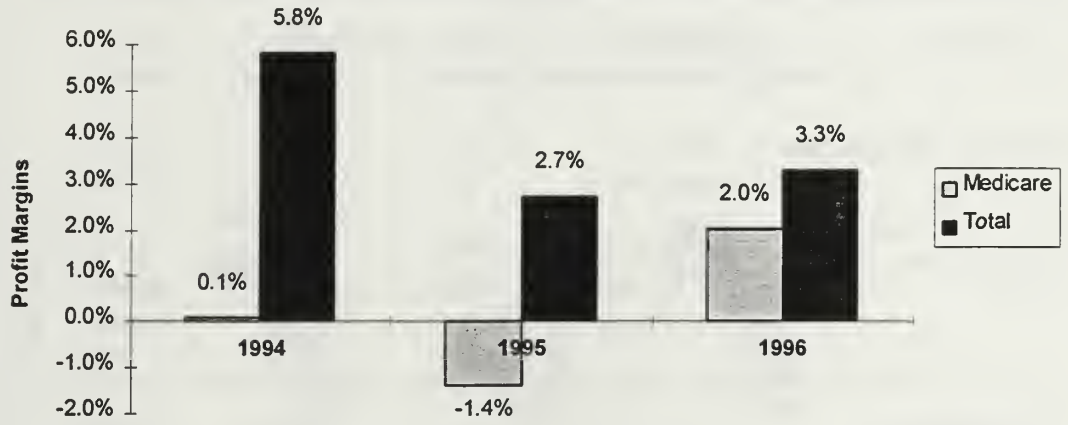
Source: *Division of Health Care Finance and Policy*

b. Medicare and Total Profit Margins

A recently published national study of the Medicare provisions of the BBA based on data submitted to the Health Care Financing Administration (the federal agency responsible for Medicare) reported that the PPS profit margin for all hospitals in the country as a whole in 1995 was 10%.[6] The report further estimated a national PPS profit margin for 1997 of 14.2%. The present analysis, based on hospital financial information submitted to the state's Division of Health Care Finance and Policy (DHCFP), found that PPS profit margins in Massachusetts were significantly below the national average.[7] Over the last three years for which state-level data were available, PPS hospitals in Massachusetts as a whole have only been close to breaking even on

the provision of inpatient services to Medicare patients. The financial statistics represented in Figure 7 below indicate that PPS hospitals earned profits of less than one tenth of one percent on Medicare-funded individuals in 1994. By 1995, these same hospitals were incurring losses of 1.4%. In 1996, Medicare profit margins rebounded to 2%, though still far below the national figure.

Figure 7
Medicare and Total Inpatient Profit Margins: 1994-1996



Source: *Division of Health Care Finance and Policy*

Small and sometimes negative Medicare profit margins across PPS hospitals in Massachusetts in recent years have been offset by positive and somewhat larger profit margins among private payers. (Medicaid profit margins are commonly reported to be even less than those for Medicare.) According to the financial statistics also presented in Figure 7, in 1994 PPS hospitals in the state as a whole earned almost 6% profit when all payers were taken into account. By 1995, total profit margins had fallen to 2.7% (mirroring the shortfall in PPS payments). In 1996, the profit margin across all payers had increased to 3.3% (again echoing the higher Medicare profit margin for that year). The aggregate financial data suggest that hospitals in Massachusetts have been able to compensate for low and sometimes negative Medicare profit margins by generating significantly higher profits among other, mostly private, insurers. An individual hospital's ability to cross-subsidize its Medicare-funded admissions from patients with private insurance will be an important factor in determining the extent to which the Medicare cutbacks mandated by the BBA can be absorbed.

c. Differences Between Acute Care Hospitals

Aggregated revenue and cost figures mask major differences in the financial performance of individual PPS hospitals in Massachusetts. These differences carry important implications for the impact of Medicare's reimbursement payment reforms. To better capture the differential effects of the Medicare provisions of the BBA on individual facilities, each hospital in the state has been classified according to the following three criteria: (1) whether or not they engage in teaching activities; (2) whether or not they treat a disproportionately high percentage of Medicaid recipients or provide a large

share of uncompensated care; and (3) size, measured in terms of number of beds.[8]

Table 1
Inpatient Statistics by Type of Hospital: 1996

Hospital Characteristic		No. of Hospitals	Medicare Share of Discharges	Medicare Share of Payment
Teaching	*Teaching*	40	37.5%	48.6%
	Non-Teaching	34	46.2%	59.3%
Disproportionate Share	*DSH*	31	36.5%	47.7%
	Non-DSH	43	45.6%	57.3%
Size	*<100 Beds*	18	47.4%	60.7%
	100-200 Beds	25	43.6%	55.9%
	>200 Beds	31	38.0%	49.0%
All Hospitals		74	42.9%	50.7%

Source: *Division of Health Care Finance and Policy*

Table 1 above categorizes Massachusetts hospitals according to these three groups. Out of a total of 74 PPS hospitals in the state for which reliable financial data were available, 40 were engaged in medical education and 31 provided a large share of free care or treated a high number of Medicaid patients. In addition, 18 short-term acute care hospitals in the state had less than 100 beds, 25 had between 100 and 200 beds, and 31 had over 200 beds. Table 1 further reveals that non-teaching facilities and non-disproportionate share hospitals admitted relatively more Medicare patients than their teaching and disproportionate share (DSH) counterparts.[9] Medicare patients were also disproportionately admitted at smaller, community-based facilities than at the state's large urban facilities. Furthermore, Medicare accounted for approximately 60% of total inpatient service revenue at these same facilities, compared with less than 50% at the larger teaching and public urban hospitals. The higher the share of Medicare patients, the harder it will be for a hospital to cross-subsidize PPS cutbacks with privately insured admissions.

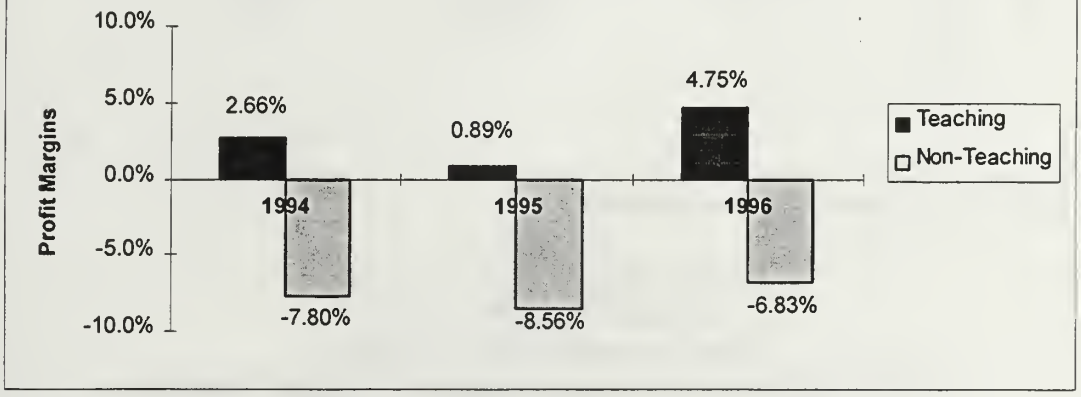
The Medicare and total profit margins for each of the three types of hospital classification described above are presented graphically below in Figures 8A-8B, 9A-9B, and 10A-10B, respectively. The financial statistics summarized in these figures make two important points. First, they confirm that Medicare profit margins are lower than total profit margins across all types of hospitals. And second, the figures illustrate that profit margins at non-teaching, non-DSH and small community hospitals are uniformly lower than those at the larger urban teaching and public institutions. This pattern is true for Medicare as well as other payers. For example, the Medicare profit margin at non-teaching hospitals in 1996 was -6.8%, compared with 4.7% at teaching facilities. Given

the lower PPS profit margin (as well as the higher share of Medicare admissions), total profit margins at non-teaching hospitals were also lower than at teaching institutions (-3.8% compared with 5.1%). A similar pattern was observed between DSH and non-DSH hospitals, as well as between small and large hospitals. In both cases, losses on Medicare-funded patients (as well as the higher share of Medicare admissions) meant that non-DSH and small community hospitals earned significantly lower overall profit margins than their DSH and larger urban counterparts.

Figure 8A

Medicare Inpatient Profit Margins:

Teaching vs. Non-Teaching Hospitals, 1996-1996

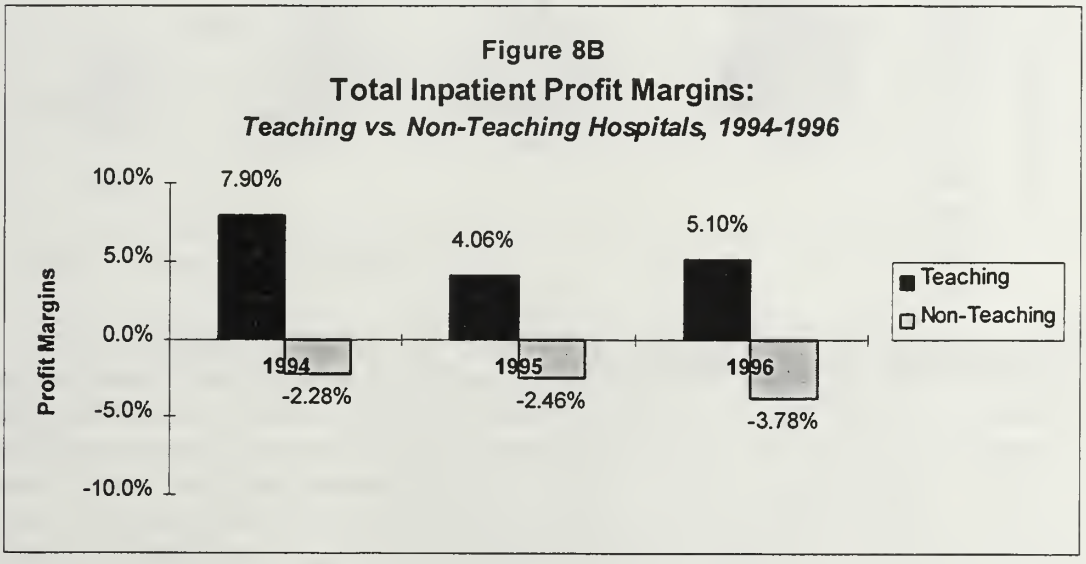


Source: *Division of Health Care Finance and Policy*

Figure 8B

Total Inpatient Profit Margins:

Teaching vs. Non-Teaching Hospitals, 1994-1996

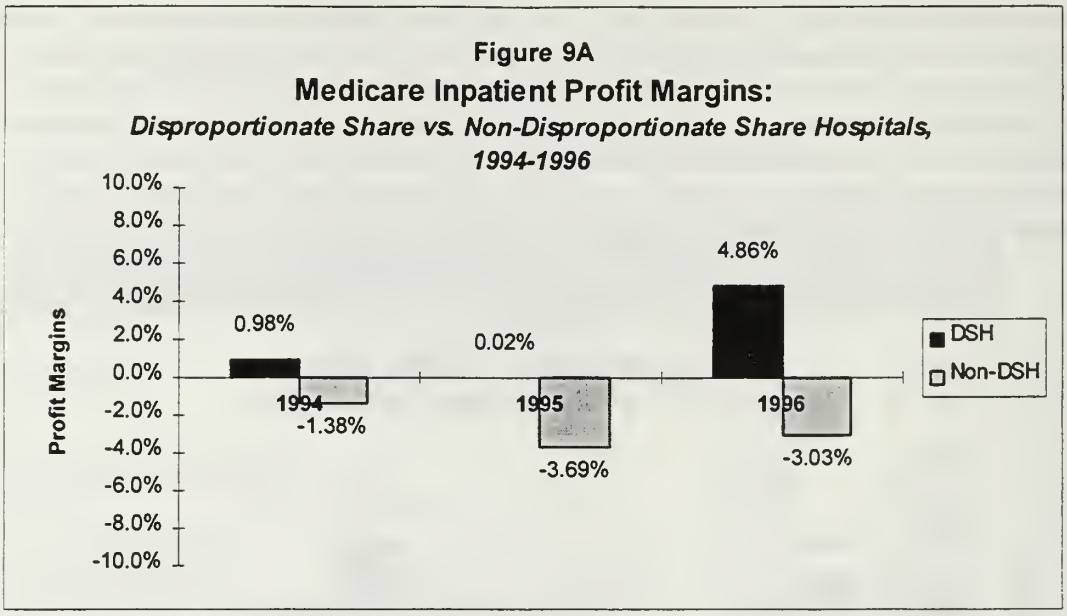


Source: *Division of Health Care Finance and Policy*

Figure 9A

Medicare Inpatient Profit Margins:

Disproportionate Share vs. Non-Disproportionate Share Hospitals, 1994-1996

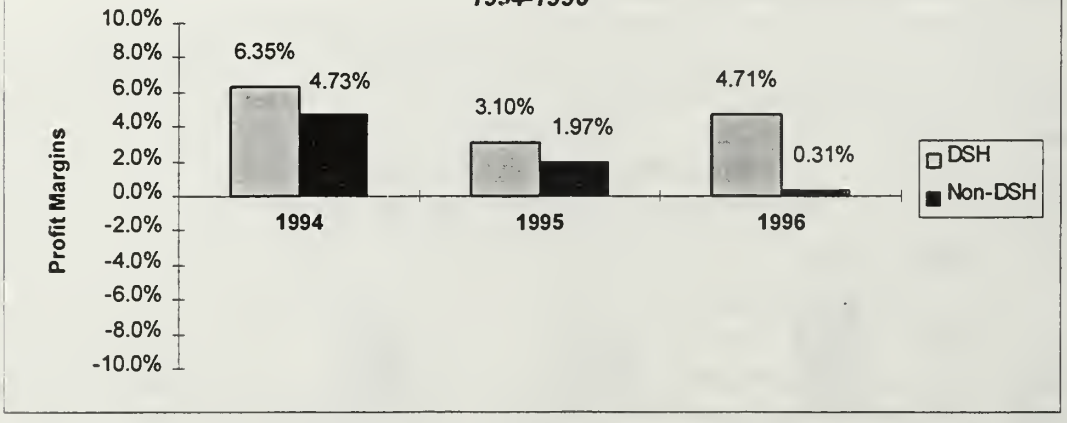


Source: *Division of Health Care Finance and Policy*

Figure 9B

Total Inpatient Profit Margins:

Disproportionate Share vs. Non-Disproportionate Share Hospitals 1994-1996

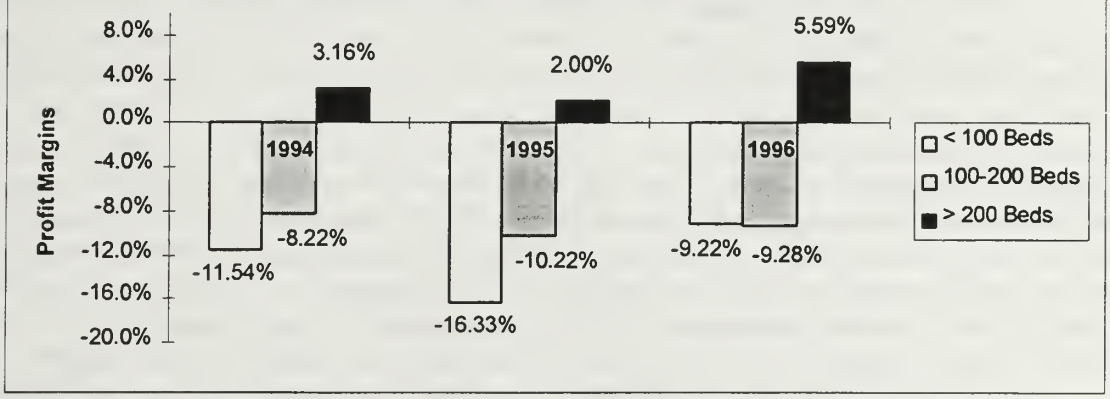


Source: *Division of Health Care Finance and Policy*

Figure 10A

Medicare Inpatient Profit Margins:

By Size of Hospital, 1994-1996

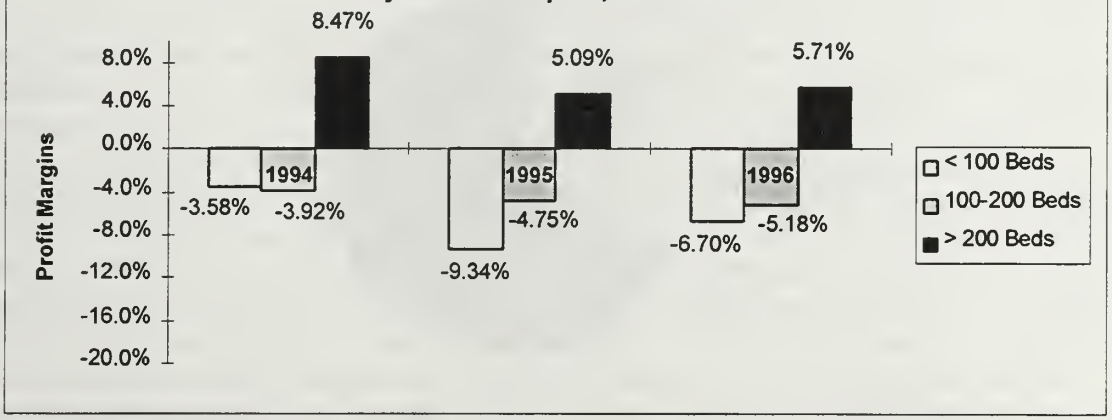


Source: *Division of Health Care Finance and Policy*

Figure 10B

Total Inpatient Profit Margins:

By Size of Hospital, 1994-1996



Source: *Division of Health Care Finance and Policy*

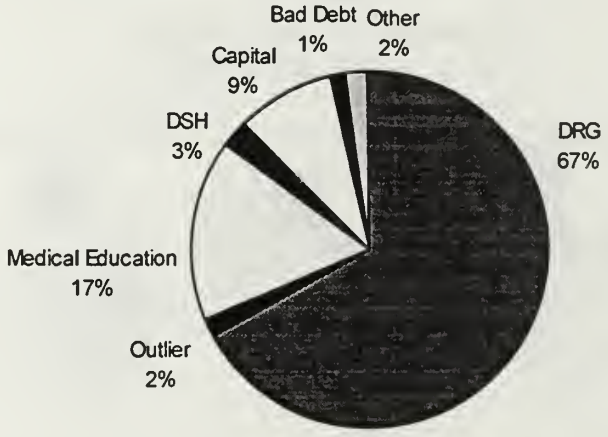
The foregoing disaggregated financial analysis suggests that hospitals with lower rates of Medicare admissions and higher profit margins on those admissions are in a better position to withstand the PPS reductions mandated in the BBA. Non-teaching, non-DSH and small community hospitals already appear to be suffering substantial losses on their Medicare patients (-6.8%, -3.0% and -9.3%, respectively, in 1996). Moreover, in each case, higher rates of profit from privately insured patients do not appear to be sufficient to pull most of them out of the red (with total profits of -3.8%, 0.3% and -6.7%, respectively). Given their lower profit margins and greater dependency on Medicare admissions, non-teaching, non-DSH, small community hospitals appear positioned to suffer the most financially from the PPS cutbacks legislated by the BBA.

3. Changes as a Result of the Balanced Budget Act

a. Medicare's Inpatient Acute Care Hospital Payment Formula

Medicare's PPS hospital reimbursement formula consists of six major components. The largest of these by far is the DRG-related payment, accounting for over two-thirds of total reimbursement to PPS hospitals in Massachusetts in 1996. (See Figure 11 below.) Under PPS, providers receive a hospital-specific base rate adjusted for wage and input price variation for each Medicare-eligible discharge. In 1997, the adjusted standardized labor-related and non-labor-related amounts for hospitals in large urban areas summed to $3,905. (Roughly 85 % of all PPS hospitals in Massachusetts are considered to be in large urban areas.) The hospital base rate is then multiplied by the cost weight associated with the diagnosis of the individual discharge to determine the DRG-related component of PPS payment.[10] For example, for a coronary bypass operation with cardiac catherization (DRG 106), hospitals in Massachusetts would receive a base payment of $3,905 multiplied by its DRG weight of 5.7109, or $22,301.

Figure 11
Composition of PPS Payments in Massachusetts: 1996



Source: *Division of Health Care Finance and Policy*

While one of the purposes of PPS was to remove the incentives for hospitals to provide more than the medically necessary level of care, additional payments are nonetheless made for exceptionally expensive cases. If the estimated standardized cost of a patient exceeds a DRG-specific cost threshold, hospitals are paid 80% of the difference. Before assessing the amount of costs to be covered, however, costs are adjusted downward for any separate payments relating to teaching and disproportionate share expenses. This means that many admissions at the teaching and DSH facilities in the state whose costs exceed the specified threshold are ultimately ineligible for outlier payments. As shown in Figure 11, outlier payments accounted for only 2% of total reimbursement to PPS hospitals in Massachusetts in 1996.

Additional payments are also provided for the extra costs associated with treating a disproportionate share of indigent patients and providing medical training. Prior to the enactment of the BBA, disproportionate share (DSH) adjustments and the

indirect medical education (IME) adjustments were applied to both DRG payments and outlier payments. In Massachusetts, adjustments for medical training (covering both direct and indirect medical education expenses) constituted the second largest component of PPS reimbursement, representing 17% of total payment in 1996. DSH payments accounted for 3% of total payments. (See Figure 11 above.) However, unlike outlier payments, IME and DSH adjustments are concentrated in fewer hospitals. In 1996, only 54% of the state's PPS hospitals received IME payments and 42% received DSH payments.

The final two major components of Medicare's prospective payment system are capital payments and compensation for enrollee bad debt. The update factor for capital costs was historically set to cover 90% of anticipated capital-related expenses. However, in 1996, with the expiration of the budget neutrality condition, capital payments were greatly increased. In 1996, capital payments accounted for 9 % of total PPS reimbursement. Finally, Medicare has also historically reimbursed hospitals for a share of its enrollee co-payments that remain unpaid. In 1996, bad debt payments represented only 1% of total reimbursement. (See Figure 11 above.) Smaller adjustments are also made for expenses related to such factors as treating end stage renal disease and organ acquisition.

b. Provisions in Balanced Budget Act Relating to Inpatient Services

The reforms enacted by the BBA make very specific adjustments to the way in which each of the components of the prospective payment system outlined above is calculated, in effect ratcheting downward the various payment parameters.[11] The major policy changes relating to reimbursement for inpatient services at PPS hospitals are summarized in Table 2 below. First, and most importantly, the operating updates (the annual adjustment to the hospital-specific base rate meant to reflect the rate of inflation in input prices) were lowered over each of the five budget years encompassed by the new law (1998-2002). Between 1990 and 1996, the operating update averaged 1.6 percentage points below the forecasted increase in the PPS market basket.[12] With no agreement in new legislation, the operating update in 1997 was 0.5 percentage points below the PPS market basket index. Between 1998 and 2002, the operating update was scheduled to equal the forecasted PPS market basket. Under the Medicare provisions of the BBA, however, the operating update was eliminated for 1998 and fixed at 1.9 percentage points below the PPS market basket in 1999, 1.8 percentage points below in 2000, and 1.1 percentage points below in 2001 and 2002. Given the importance of the DRG-related component in total payments, this reduction in the operating update accounts for the greatest share of the projected Medicare program savings under the BBA.

Table 2
Medicare Provisions of the BBA of 1997 Relating to Acute Care Hospitals

Major Provisions Relating to Inpatient Payments

Operating Updates	*The BBA establishes a 0% operating update for 1998; the increase in market basket (MB) minus 1.9 percentage points in 1999; MB minus 1.8 percentage points in 2000, and MB minus 1.1 percentage points in 2001 and 2002. For 2003 and subsequent years, BBA provides the full MB increase for all PPS hospitals.*
Capital Updates	*The BBA re-bases capital payments by the budget neutrality factor that was in effect as of September 30, 1997, which is equivalent to a 15.68% reduction of the unadjusted Federal capital payment rate. For discharges occurring from October 1, 1997 through September 30, 2002, the BBA makes an additional 2.1% reduction in capital payments.*
IME Adjustments	*The BBA revises the Indirect Medical Education (IME) formula to reduce the IME adjustment factor from approximately a 7.7% increase for every 10% increase in a hospital's resident-to-bed ratio to a 7% increase in 1998; a 6.5% increase in 1999; a 6.0% increase in 2000; and a 5.5% increase in 2001 and 2002*
DSH Adjustments	*The BBA lowers Medicare disproportionate share (DSH) payments to eligible hospitals by 1% in 1998, 2% in 1999, 3% in 2000, 4% in 2001 and 5% in 2002.*
Outlier Adjustments	*The BBA eliminates the IME and DSH adjustments attributable to outlier payments. In addition, the fixed loss cost outlier threshold, used to compare costs to payments, will now be based on the sum of DRG payments and IME and DSH payments. In response, the estimated cost of a case will no longer be reduced by the IME and DSH payments. The BBA phases out day outliers as well.*
Bad Debt Payments	*The BBA reduces payment for enrollee bad debt by 25% in 1998, by 40% in 1999 and by 45% in subsequent fiscal years. The BBA also disallows any reduction in Medicaid co-payments to be treated as bad debt.*
Transfer Payments	*The BBA redefines the movement of patients from PPS hospitals to post-acute care providers (skilled nursing facilities, PPS-exempt hospitals and home health) as "transfers" as opposed to "discharges" for 10 high volume diagnosis-related groups (DRGs). The payment for these post-acute care transfers cannot exceed the sum of 50% of the regular transfer payment and 50% of the regular DRG payment. The BBA allows the number of DRGs and post-acute settings to be increased in 2001.*
Consolidated Billing	*The BBA prevents hospitals from directly billing Medicare for ancillary services provided to residents of long-term care facilities. Hospitals must seek payment for these services directly from the resident care facility.*

Major Provisions Relating to Outpatient Payments

Operating and Capital Payments	*Eliminates formula driven overpayment beginning October 1, 1997. The BBA also extends 5.8% overall payment reductions and 10% capital payment reductions through 1999.*
Prospective Payment System	*The BBA authorizes a prospective payment system based on Ambulatory Payment Classifications (APCs) for hospital outpatient departments (excluding ambulance and occupational and physical therapy services) to become effective on January 1, 1999.*

The BBA makes significant reductions in payments for capital-related expenditures as well. The Medicare provisions of the BBA re-based capital payments to reflect the historical budget neutrality factor. The result is a permanent reduction in the rate of payment for capital costs of 15.68 %. The BBA further implemented a temporary reduction in the capital reimbursement rate of an additional 2.1% for discharges occurring within the five year period encompassed under the new legislation.

The other major areas of reform relate to Medicare adjustments for IME and DSH-related expenditures, as well as for enrollee bad debt.[13] The BBA lowered DSH payments by one percent annually in each of the next five years. In addition, the BBA revised the formula used to calculate payment for indirect teaching-related expenses by reducing the IME adjustment factor from a 7.7% increase for every 10% increase in a hospital's resident-to-bed ratio to a 7% increase in 1998, a 6.5% increase in 1999, a 6% increase in 2000 and a 5.5% increase in 2001 and 2002.[14] The result of the formula change is an approximate 29% reduction in IME payments to PPS hospitals over the next five years. The Medicare provisions of the BBA also called for a reduction in the amount of payment for enrollee bad debt that PPS hospitals would otherwise expect to receive by 25% in 1998, 40% in 1999 and 45% in 2000 and thereafter.

Another major area of reform under the BBA concerns the calculation of outlier payments. Historically, IME and DSH adjustments were applied to both the DRG payment as well as the outlier payment. The BBA, however, removed the outlier payments from the IME and DSH adjustments so that now they are based on the DRG payment alone. In response, HCFA decided to no longer standardize costs for IME and DSH payments. On the one hand, teaching and disproportionate share hospitals will now receive smaller IME and DSH adjustments since they are no longer based on outlier payments. But, on the other hand, a larger share of their admissions will now qualify for outlier payments under the BBA since estimated costs are no longer reduced for IME and DSH adjustments. Since most community hospitals do not qualify for IME and DSH payments, they will be unaffected by these changes. The net effect on the larger, urban teaching and disproportionate share facilities is unclear.

Finally, the BBA incorporates several potentially important changes in the way in which PPS hospitals are reimbursed for continuing care patients. One aspect of this reform is a reduction in the amount of payment PPS hospitals receive for some patients transferred to post-acute care facilities, which, often times, are part of the same financial entity. Under the new regulations, hospitals will receive an amount not to exceed the sum of 50% of the regular DRG payment plus 50% of the regular transfer payment for such discharges. The new rules are to be tested initially on ten 'high volume' DRGs yet to be determined. The BBA allows for future expansion in the number of both DRGs and post-acute care facilities included in this category.

A secondary issue relating to continuing care patients has to do with consolidated billing procedures. Prior to the BBA, acute care hospitals billed Medicare directly for ancillary and medical services that they provided to residents of long-term care facilities. Under the BBA, however, hospitals will no longer be able to bill Medicare directly for these procedures. The costs associated with providing ancillary services to residents of nursing facilities must now be recovered from the long-term care facility

directly. [15] A discussion of the impact of these continuing care provisions is provided in the skilled nursing facility section of this report.

c. Provisions in Balanced Budget Act Relating to Outpatient Services

The BBA also carries several provisions relating to Medicare's reimbursement of outpatient services at PPS hospitals. [16] The immediate effects of the outpatient provisions are to eliminate the formula-driven overpayments in 1998 and to extend the 5.8% overall and the 10% capital cost reductions through 1999. [17] More importantly for the future, however, the BBA authorizes the Secretary of Health and Human Services to develop and implement a prospective payment system to reimburse PPS hospitals for the provision of outpatient services. Ambulance and laboratory services, as well as physical, occupational and speech therapies, are excluded from the proposed outpatient PPS. The outpatient PPS is scheduled to take effect on January 1, 1999 with no phase-in period.[18]

While details of the outpatient PPS have not been worked out, it will be based on the Ambulatory Payment Classifications (APC) system. A similar outpatient PPS system was initiated by Massachusetts Medicaid in October of 1997 (starting with Phase I for significant procedures). Under the Medicare system, all patients are categorized into one of 300 APCs based on procedures, visits and ancillary services. Services within APCs are similar both clinically and in relative resource use. Unlike with the inpatient DRG system, however, a patient can qualify for more than one APC at a time. Medicare's 1996 claims records and the 'most recent' hospital cost reports will be used to calculate weights for each APC based on the relative median cost of treating each group. A conversion factor will be used to convert weights to payment rates. Payments will be budget neutral based on projected 1999 payments under the current system. The annual increase in payment rates will equal the hospital market basket minus one percentage point for years 2000 through 2003. A market basket for hospital outpatient services may be developed for future use.

Co-payments are fixed at 20% of the 1996 national median charges for each group, trended forward to 1999. The coinsurance amount per group will then be frozen, while total payment will be updated annually. Once co-payments equal 20% of a group's total payment, both coinsurance and total payment will be updated annually.[19] Under outpatient PPS, hospitals may also elect to reduce co-payments to no less than 20% of the Medicare total payment and advertise their reduced rates. Once the co-payment is determined, rates cannot be changed during the year. Unlike inpatient PPS, foregone outpatient co-payments cannot be claimed as bad debt.

4. Impact of the Balanced Budget Act

The financial analysis provided in this section focuses primarily on the impact of the BBA provisions on *inpatient* PPS payments. A general discussion of the anticipated effects of switching to a prospective payment system for outpatient services is included at the end of this section. Base year cost and revenue data were obtained from the 1996 hospital cost reports on file with the state's DHCFP. The Medicare case mix indices used to adjust per case costs were derived from the hospital discharge files also maintained by DHCFP. Medicare payment data, used as the basis for calculating the

percentage change in revenue both with and without the BBA provisions, were taken from the 1995 hospital cost reports submitted to HCFA, the most recent year for which data were available.

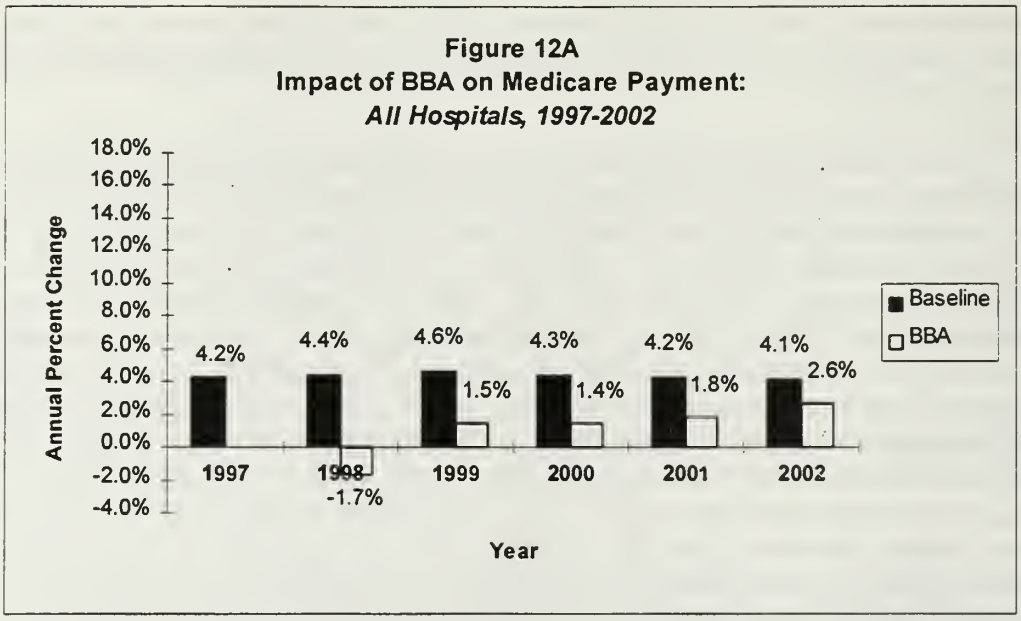
This section starts by estimating the percentage change in Medicare payments, as well as the Medicare and total profit margins, for the base year of 1997. Using the federal payment regulations both before and after the enactment of the BBA, this section then forecasts revenue and profit margins for each of the subsequent five budget years. Each figure in this section compares the predicted revenue and profit margins under the PPS provisions of the BBA with those that would have been likely to occur under the previously existing federal guidelines.[20] Under both payment scenarios, the growth in the Medicare case mix (a measure of the average severity of admissions at PPS hospitals) is assumed to decline by one tenth of one percentage point each year, starting with 2.0% in 1997. This assumption reflects the past three year trend in Massachusetts and is consistent with that used in HCFA's federal study. Hospital costs are assumed to increase annually by the conservative rate of 2.0%.[21] Reflecting the previous legislation, the baseline PPS operating updates over the next five years are assumed to equal the percentage change in the forecasted market basket. Based on past trends, baseline capital payments are assumed to increase at an annual rate of two percentage points less than the change in the forecasted market basket. The full set of assumptions and payment adjusters used in this section to estimate revenue and profit margins under both the baseline and BBA scenarios is provided in Tables B1.1 and B1.2 in the Appendix B.

Only five of the payment changes listed in Table 2 above are incorporated in the proceeding financial analysis. These include changes to the operating and capital updates, adjustments for IME and DSH payments, and reductions in enrollee bad debt payments. Calculating the effect of the changes in outlier and transfer payments requires patient-specific cost and revenue data and, hence, could not be recovered from the hospital-level cost reports used as the basis for this analysis. A discussion of the methodology used to calculate inpatient baseline revenue and costs and to apply to the annual payment changes to the baseline data appears in the Appendix B.

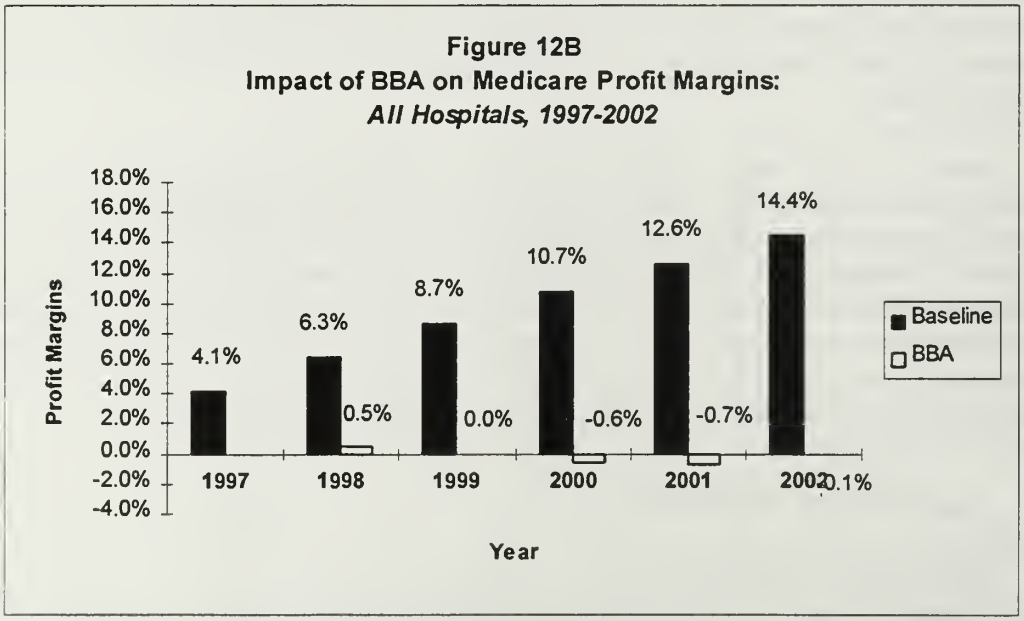
a. Impact on Providers

Impact on Inpatient Services

Not surprisingly, the financial statistics depicted in Figures 12A-12B below show a steep decline in revenues and profit margins during the first of the five budgetary years encompassed by the BBA. Medicare payments to the Massachusetts PPS hospital sector as a whole are expected to fall by 1.7% in 1998. Without the BBA, Medicare payments would have risen by an estimated 4.4% in 1998. Similarly, PPS profit margins across all general acute care hospitals in the state are expected to decline to 0.5% in 1998 under the BBA, compared with an estimated PPS profit margin of 4.1% in 1997. Without the BBA, Medicare profit margins would have reached an estimated 6.3%.



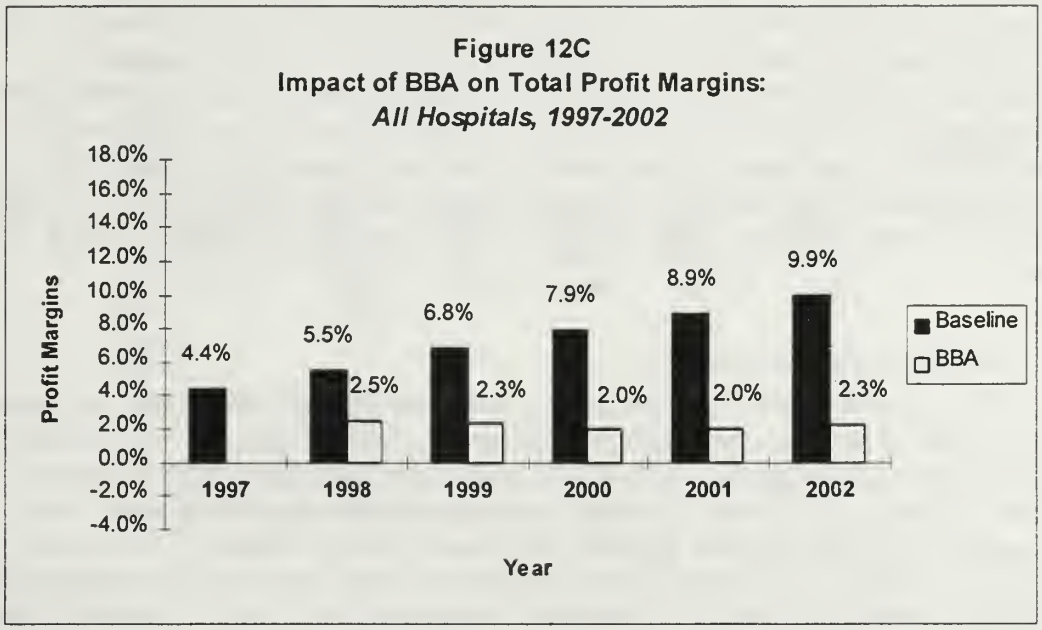
Source: *Division of Health Care Finance and Policy*



Source: *Division of Health Care Finance and Policy*

Figure 12C below provides comparable data on profit margins for all payers. According to this analysis, total profit margins for the PPS sector as a whole fall but remain positive following the implementation of the BBA. Starting from a base year total profit margin of 4.4%, total profit margins were estimated to drop to 2.5% during the first year of the new legislation, compared with 5.5% without the reforms. To provide a more accurate indication of how the inpatient provisions of the BBA will affect individual providers, a weighted average of total profit margins is also provided in which each hospital's own profit margin is weighted by its share of sector-wide costs. The results, illustrated in **Figure 12D** below, reveal that hospital-level total profit margins fall on

average from 3.1% in 1997 to an estimated 1.3% in 1998 with the BBA. In contrast, hospital-level profit margins would have reached an estimated 4.3% if the Medicare provisions of the BBA had not been enacted.



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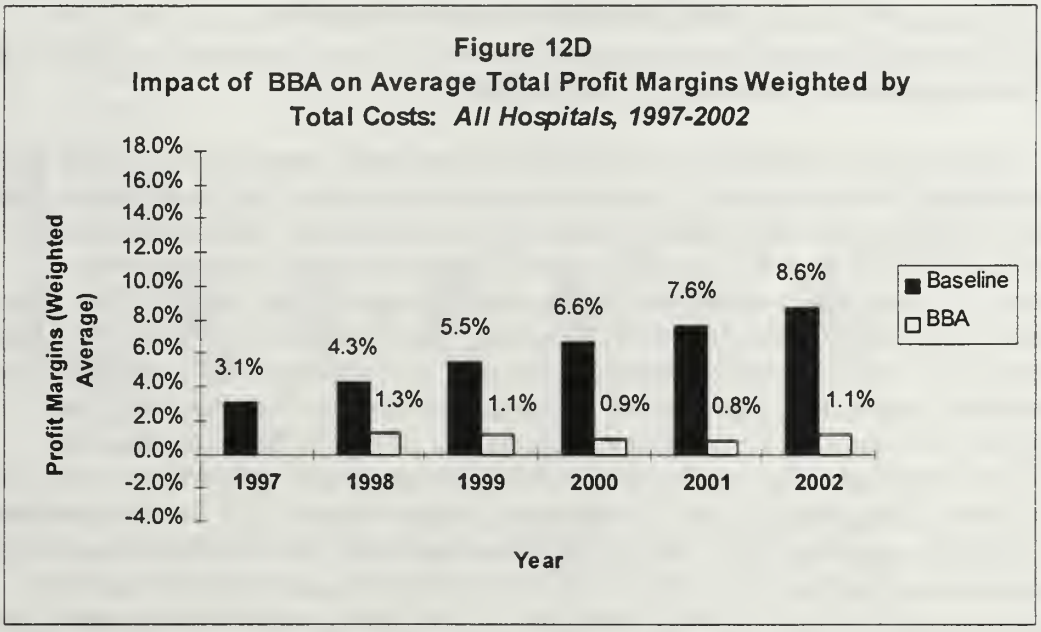


Source: *Division of Health Care Finance and Policy*

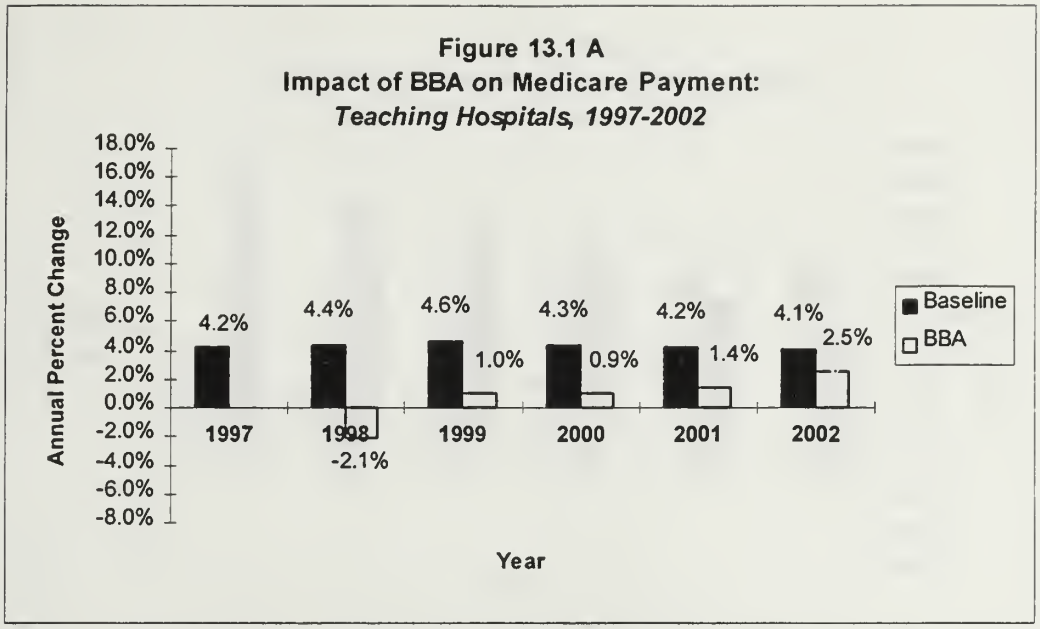
The analysis presented in Figure 12A above further reveals that the largest drop in Medicare payment occurs in the first year of the new legislation (reflecting the relative importance of the one-year freeze in the PPS operating update). After the initial drop in 1998, Medicare payments to Massachusetts hospitals begin to rise again. The positive rate of growth in PPS payments, however, is less than the anticipated rate of increase

without the policy reform. More significantly, the expenditure growth under the BBA falls short of the estimated two percent annual increase in input prices, resulting in a shrinking PPS profit margin. As shown in Figure 12B above, PPS profit margins are predicted to fall to almost zero (-0.1%) for all hospitals combined by 2002, compared with a potential 14.4% Medicare profit margin in 2002 without the policy change. As a result of the new legislation, the profit margin with all payers taken into account is expected to fall to 2.3% in 2002, about half the amount earned in the year prior to the implementation of the BBA. Total profit margins would otherwise have reached an estimated 9.9%. (See Figure 12C above.) On average, hospital-level total profit margins weighted by their share of total expenditures are expected to fall on average to 1.1% in 2002 under the BBA, compared with 8.6% without the BBA. (See Figure 12D above.)

Impact By Type of Hospital

The next three sets of graphs present the same financial information for each of the three types of hospital classification. Figures 13.1A-13.1D present information on teaching hospitals and Figures 13.2A-13.2D portray the analysis for non-teaching hospitals. Similarly, the financial results for disproportionate share and non-disproportionate share hospitals appear in Figures 14.1A-14.1D and 14.2A-14.2D, respectively. Finally, the quantitative analysis for the large, medium and small hospitals (measured in terms of bed size) is depicted in Figures 15.1A-15.1D, 15.2A-15.2D, and 15.3A-15.3D, respectively. Each set of figures illustrates the impact of the Medicare provisions of the BBA on revenue, PPS profit margins, total profit margins, and weighted average total profit margins over the next five years. The primary purpose of this section is to highlight the differences in the ability of individual hospitals to absorb the Medicare payment cutbacks enacted by the BBA.

The graphs predictably reveal that small community hospitals that do not receive supplementary compensation for teaching-related expenses or for the additional costs of treating a disproportionately large share of indigent patients will fare notably worse under the BBA than their larger, more-urban teaching and public counterparts. Interestingly, payments to non-teaching hospitals initially drop less steeply and, later, increase more rapidly than to teaching hospitals. (See Figures 13.1A and 13.2A below.) The disparity in rates of payment between teaching and non-teaching hospitals reflects the additional cuts in IME adjustments. However, because of their baseline lower profitability, non-teaching hospitals are much harder hit by the BBA reforms. As information provided in Figures 13.1B and 13.2B below shows, the PPS profit margin for the 34 non-teaching hospitals as a whole is expected to fall to -7.2% in 1998 and reach -3.1% by 2002, compared with 2.8% and 0.7%, respectively, for the 40 teaching facilities. As evidenced in Figures 13.1C and 13.2C, the total profit margin for non-teaching hospitals is expected to be -4.0% in 1998 and -1.6 % at the end of the legislative period, compared with 4.2% and 3.2%, respectively, for teaching facilities. On average, non-teaching hospitals are expected to incur losses of 1.1% in 1998 and 0.6% in 2002, compared to profits of 2.4% and 1.8 %, respectively, at the teaching institutions. (See Figures 13.1D and 13.2D below.)



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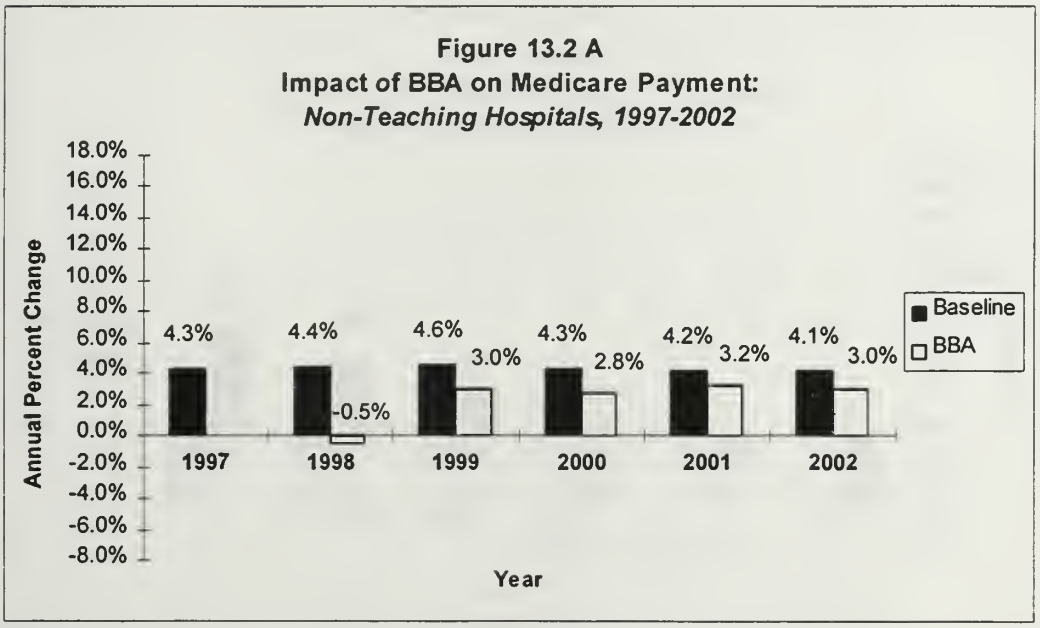

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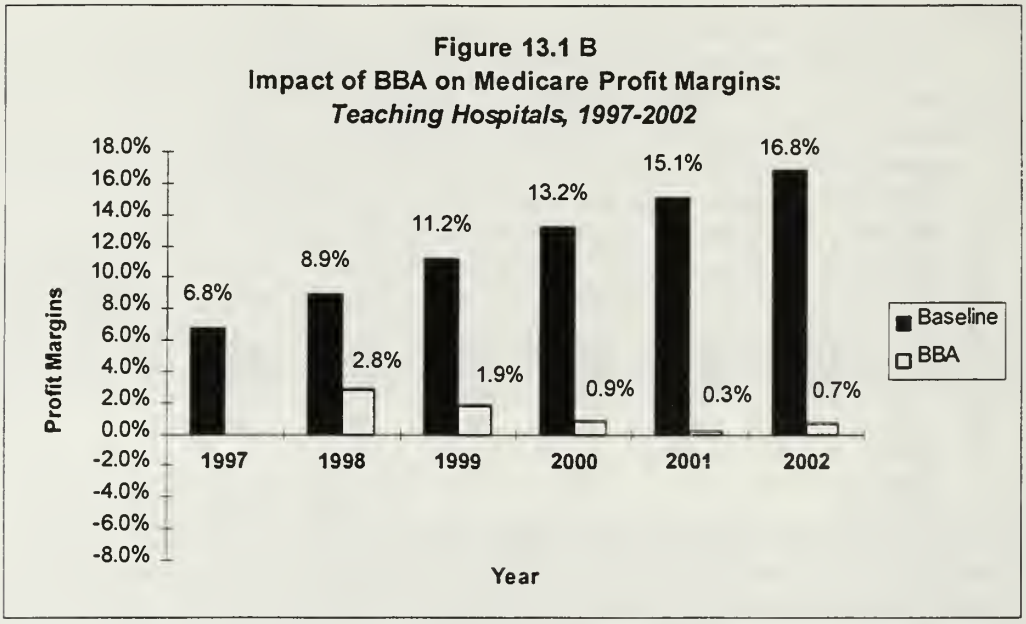

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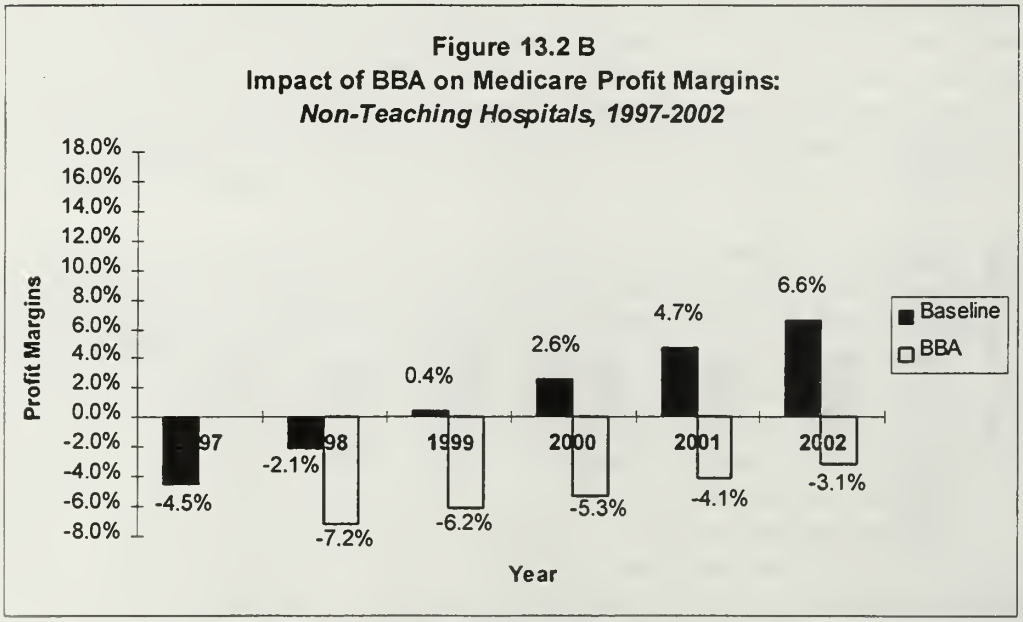

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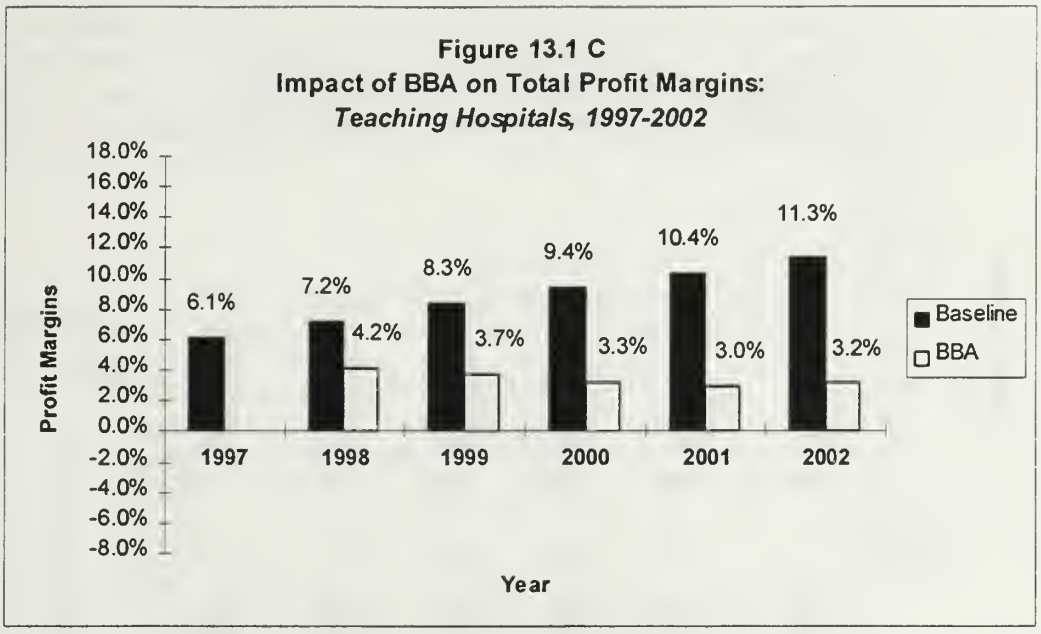

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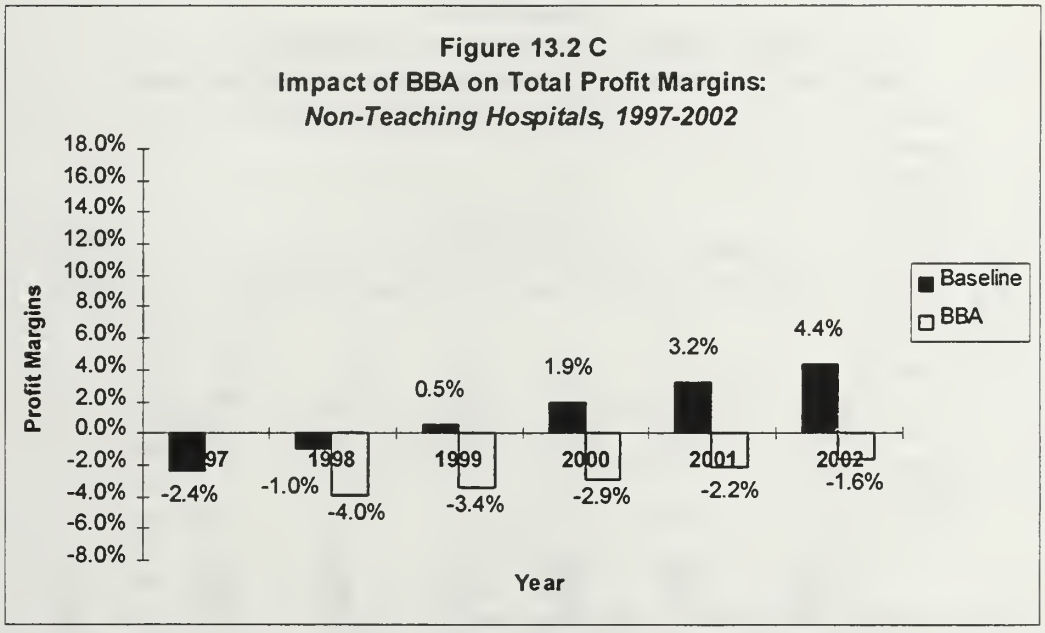

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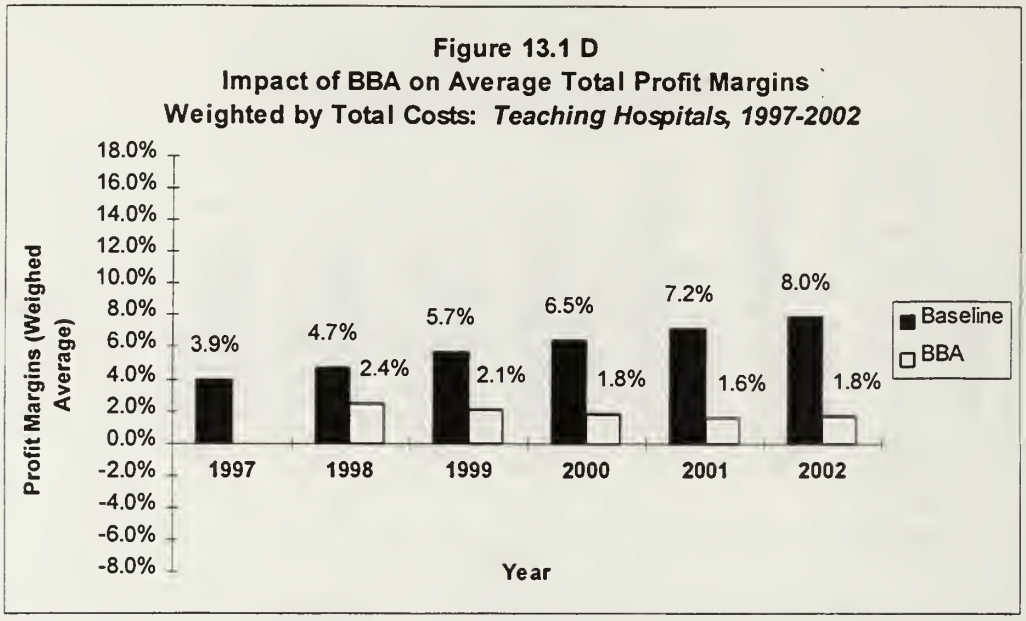

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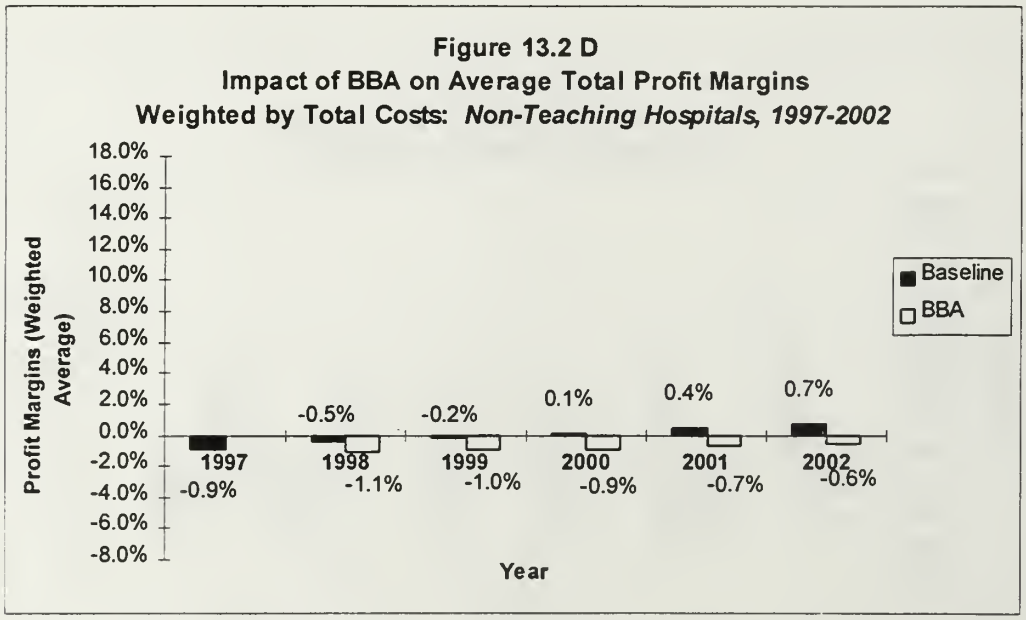
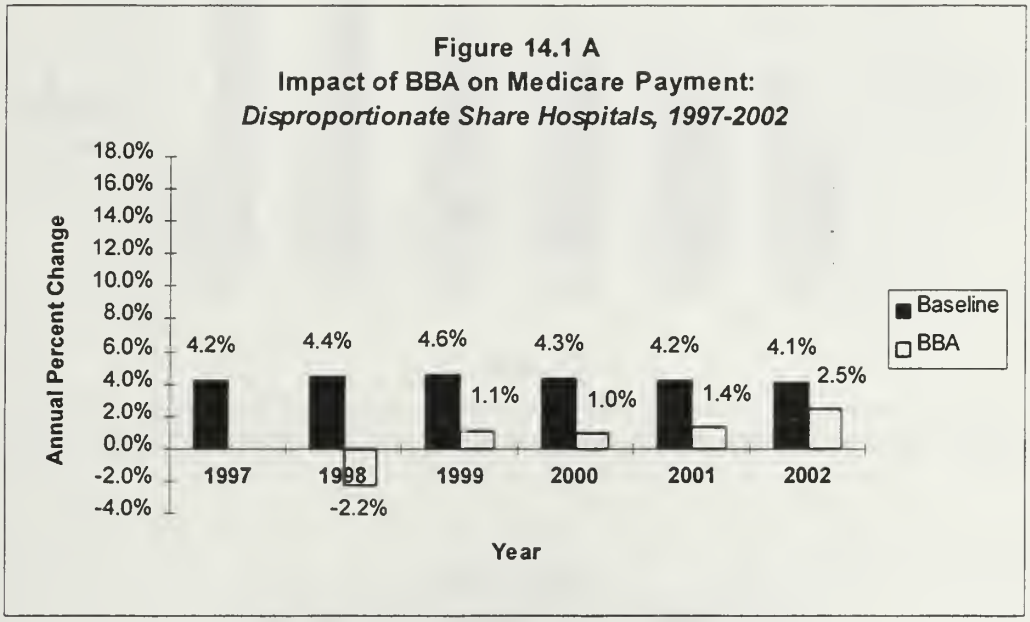


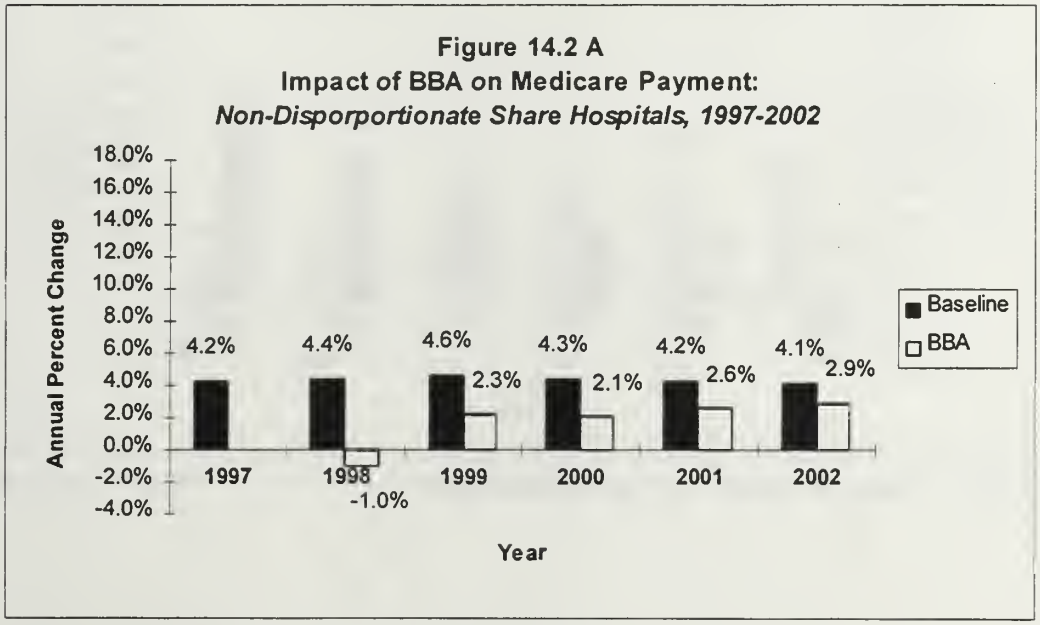
Source: *Division of Health Care Finance and Policy*

A similar situation occurs between DSH and non-DSH hospitals. (Please refer to Figures 14.1A-14.1D and 14.2A-14.2D below.) PPS payments to non-DSH hospitals initially drop less steeply and then increase more rapidly than to DSH hospitals (due to the reductions in DSH payments), but profit margins remain much lower. In fact, unlike for non-DSH hospitals, the PPS profit margin for DSH hospitals remains positive throughout the legislative period. The 31 DSH hospitals are expected to earn positive profits on their Medicare patients of 2.9% in 1998 and 0.9% in 2002, while the 43 non-DSH hospitals are predicted to experience losses of 3.8% and 2.0%, respectively.

When all payers are taken into account, DSH hospitals are expected to earn significant profits of 3.8% in 1998 and 2.8% in 2002 under the BBA. The total profit margins at non-DSH hospitals over the legislative period are negligible. On average, DSH hospitals will be earning an expected profit of 1.3% in 2002, while non-DSH hospitals will be suffering a loss of 0.1%.



Source: *Division of Health Care Finance and Policy*



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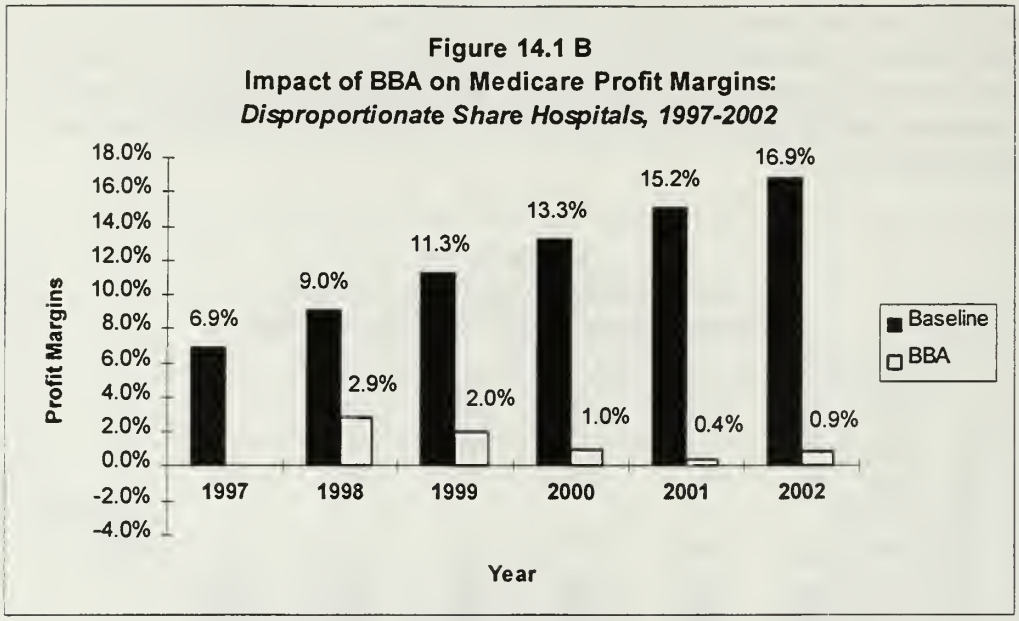

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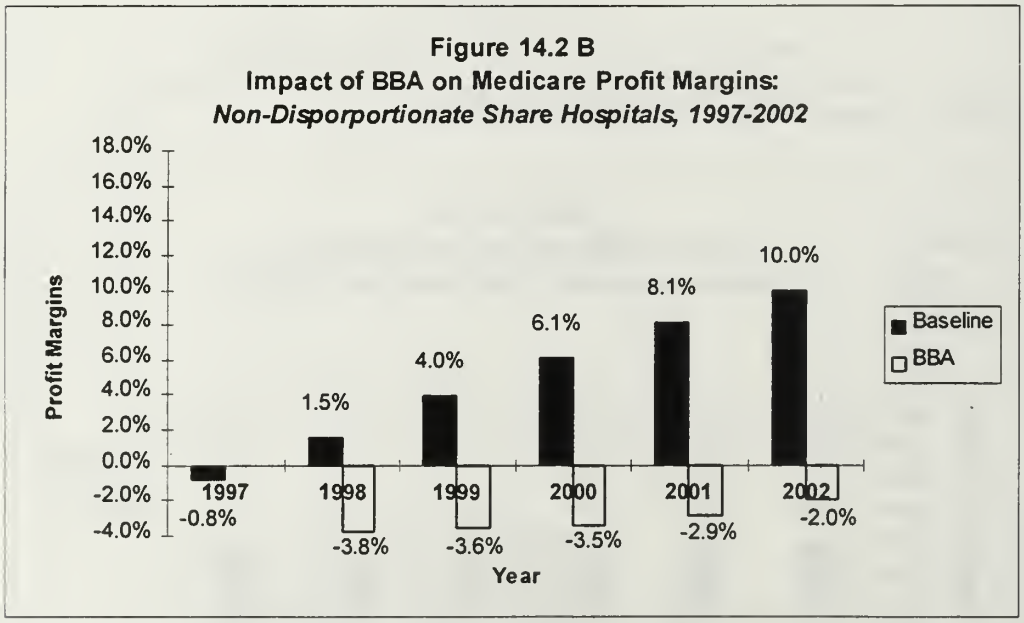

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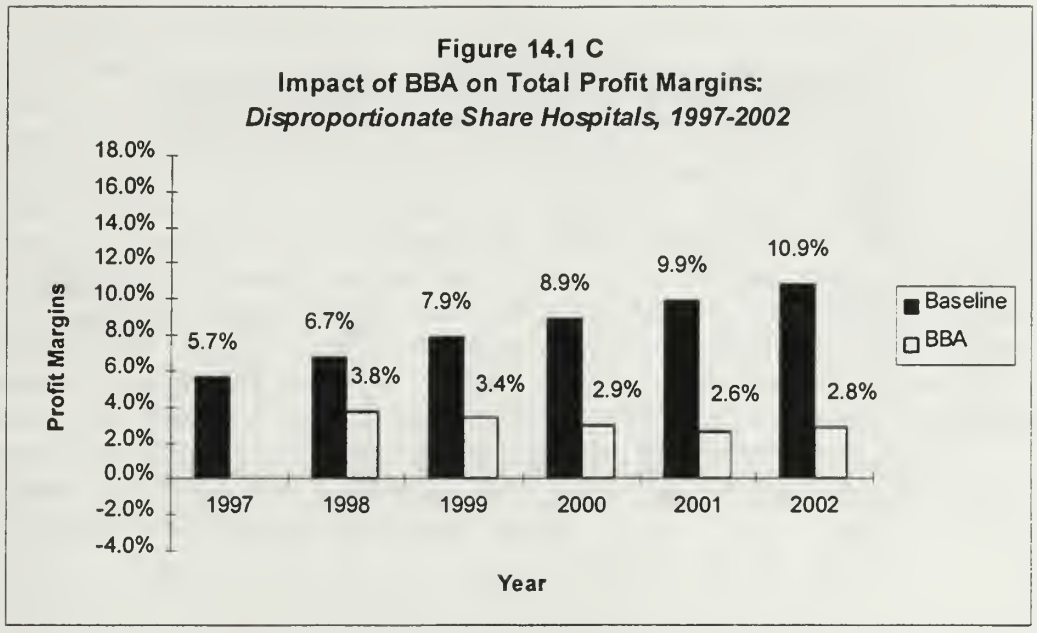

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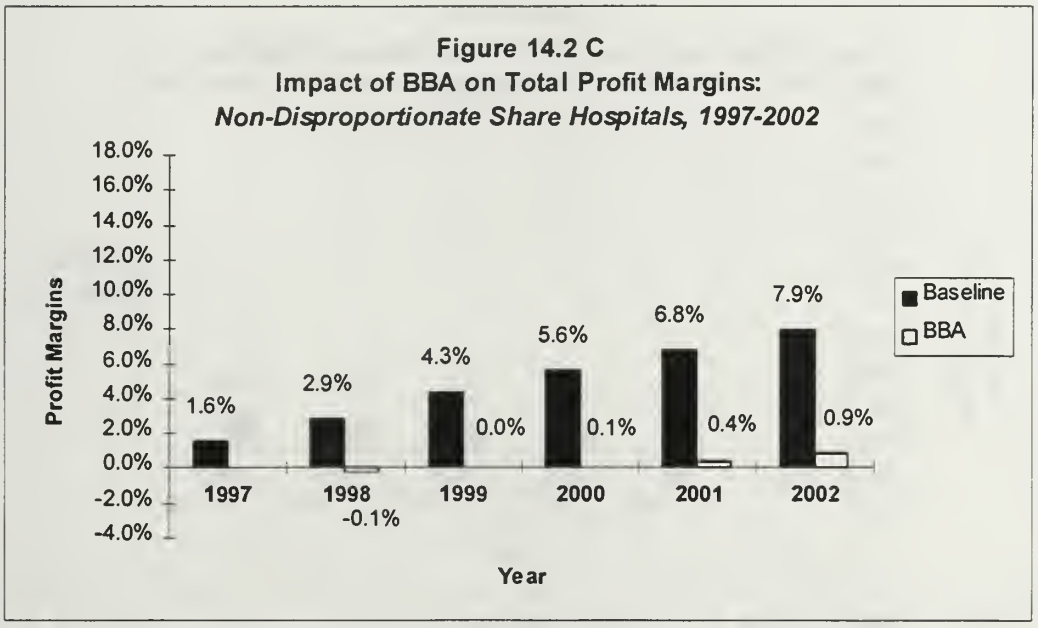

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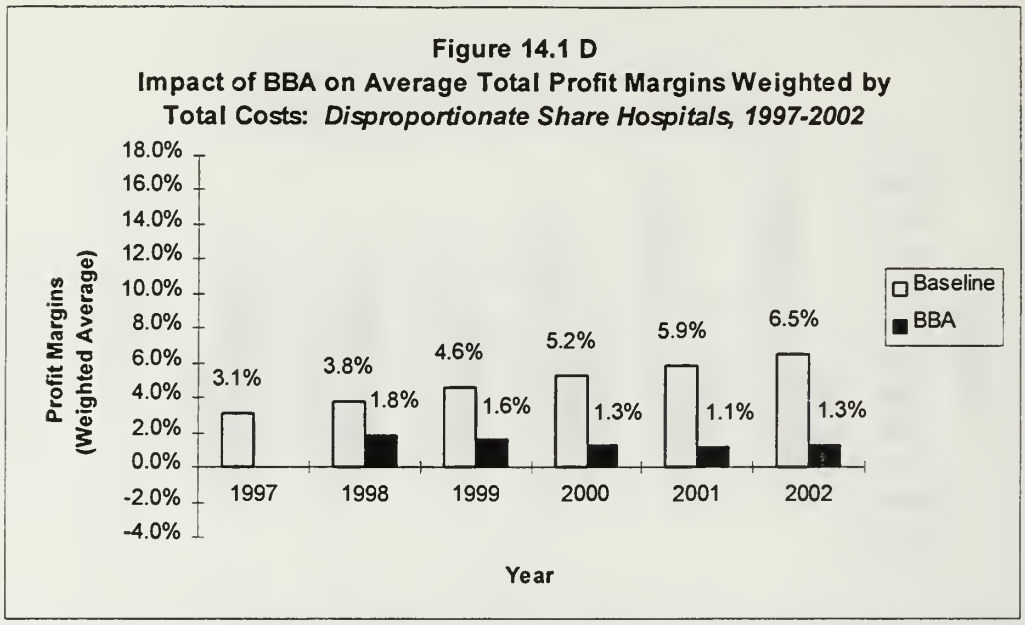

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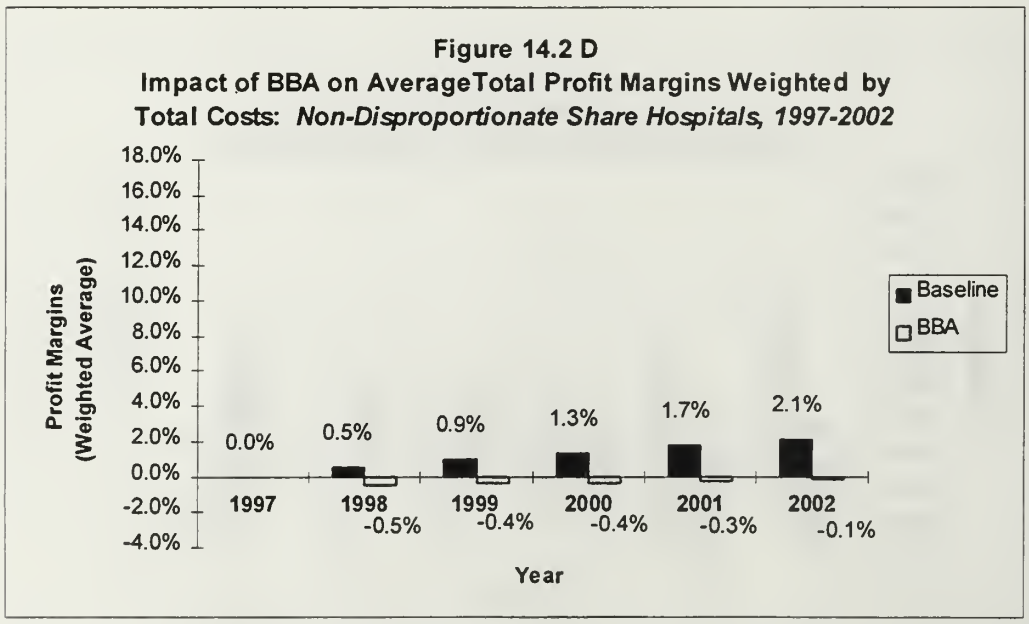

Source: *Division of Health Care Finance and Policy*

Comparable disparities hold true for small community hospitals and large, urban medical centers, with the notable exception that the losses sustained by the former are much greater than those evidenced earlier for either non-teaching and non-DSH facilities. (The disaggregated financial analysis by size of hospital is presented graphically below in Figures 15.1A-15.1D, 15.2A-15.2D, and 15.3A-15.3D.) Under the BBA reforms, the 18 hospitals with less than 100 beds will suffer PPS losses of 9.6% in 1998 and 6.1% in 2002. At the opposite end, the 31 hospitals with more than 200 beds earn profits on their Medicare admissions of 3.7% and 1.8%, respectively, despite the fact that most of these facilities are also engaged in teaching and treat a high share of indigent patients. When all payers are taken into account, small hospitals are expected to sustain losses of 6.9% and 4.9% in 1998 and 2002, respectively, compared with profits of 4.8% and 3.9%, respectively, at their large urban counterparts. Interestingly, however, large hospitals are expected on average to incur slight losses on all admissions of 0.1% in 2002, suggesting that a few of the very large facilities will not perform as well as other hospitals in their group.

Figure 15.1 A
Impact of BBA on Medicare Payment:
Hospitals with less than 100 beds, 1997-2002

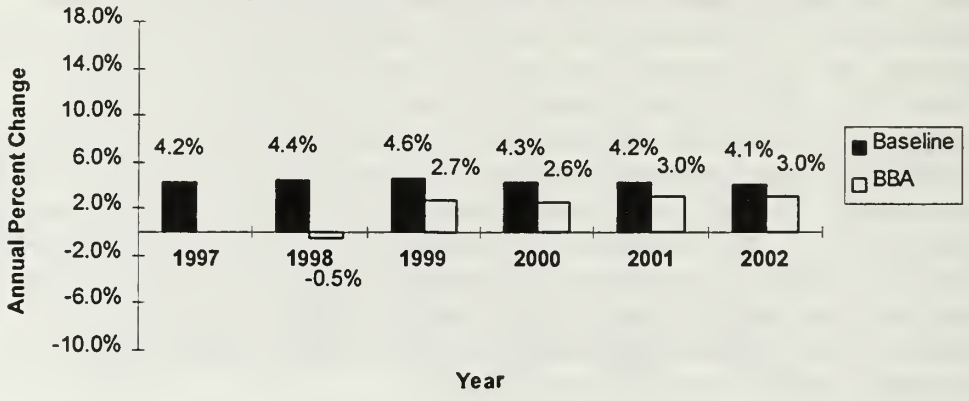

Figure 15.2 A
Impact of BBA on Medicare Payment:
Hospitals with between 100-200 beds, 1997-2002

Figure 15.3 A
Impact of BBA on Medicare Payment:
Hospitals with more than 200 beds, 1997-2002

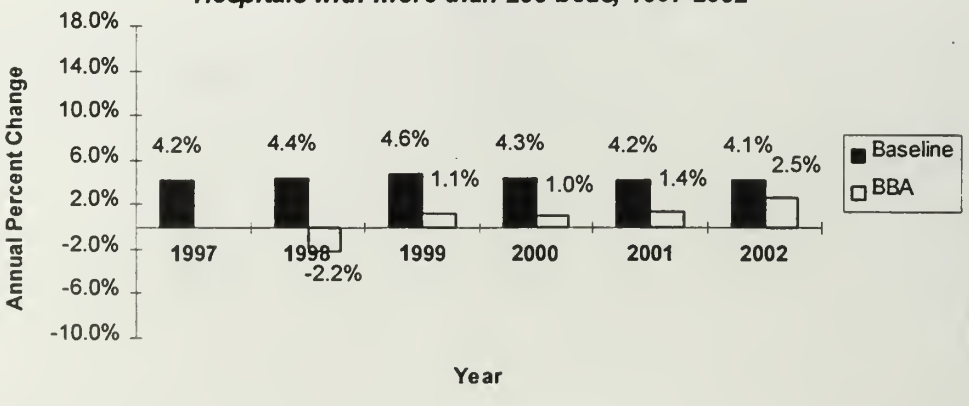

Figure 15.1 B
Impact of BBA on Medicare Profit Margins:
Hospitals with less than 100 beds, 1997-2002

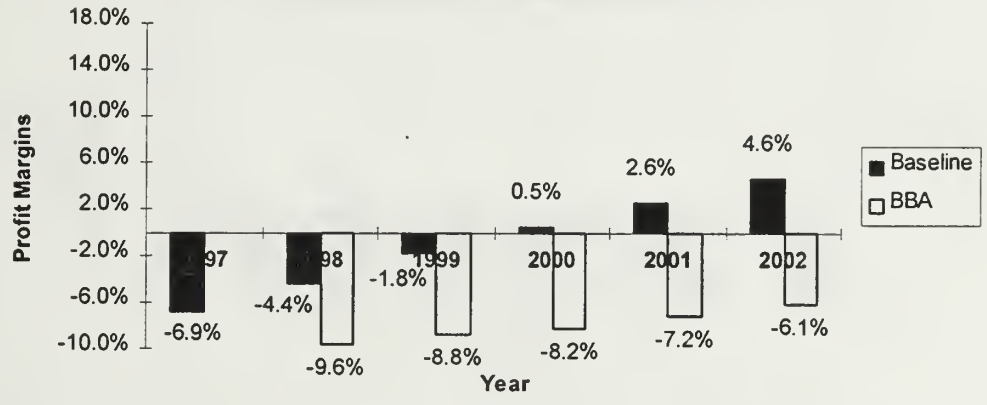

Figure 15.2 B
Impact of BBA on Medicare Profit Margins:
Hospitals with between 100-200 beds, 1997-2002

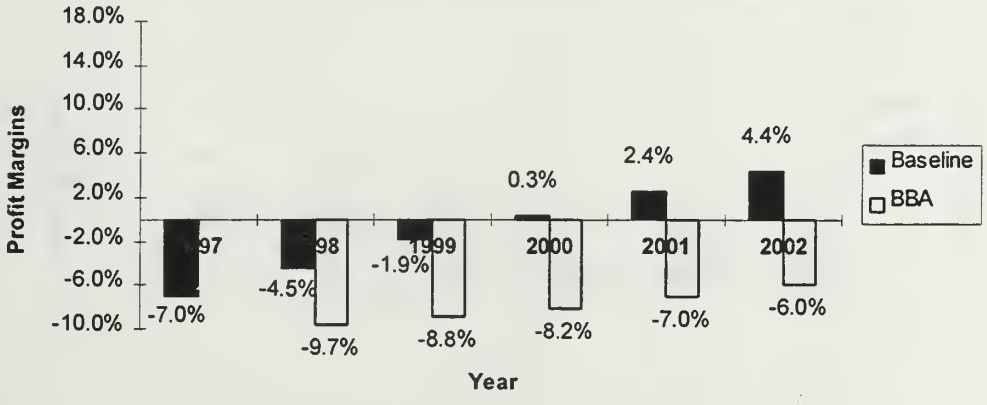

Figure 15.3 B
Impact of BBA on Medicare Profit Margins:
Hospitals with more than 200 beds, 1997-2002

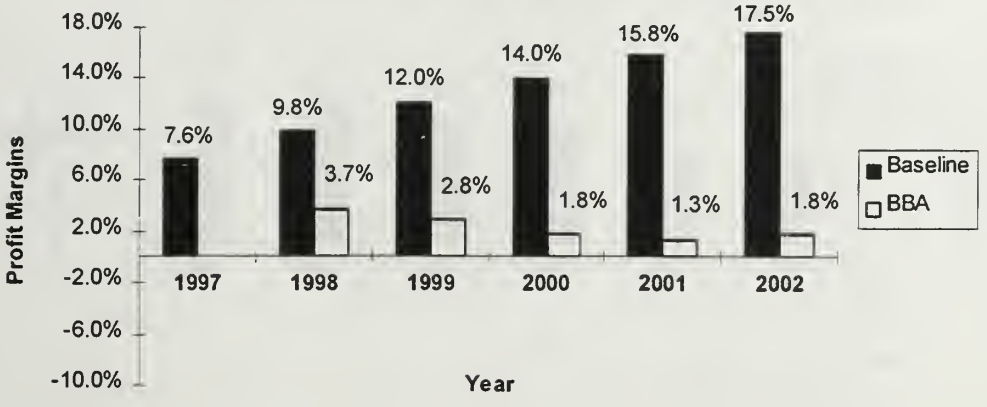

Figure 15.1 C
Imapct of BBA on Total Profit Margins:
Hospitals with less than 100 beds, 1997-2002

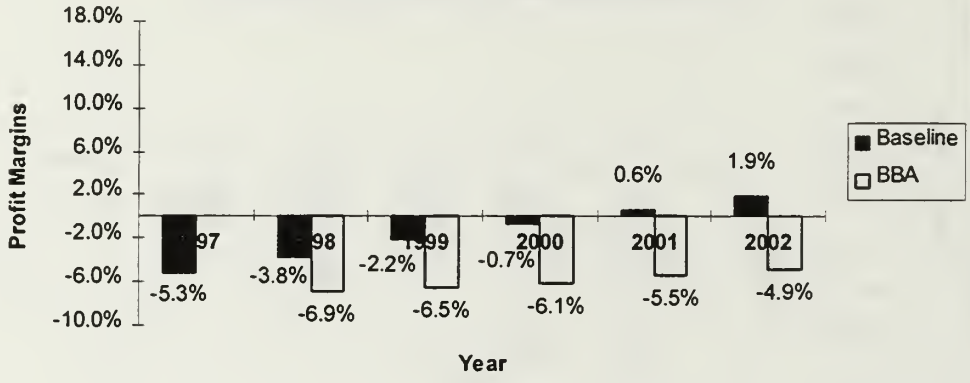

Figure 15.2 C
Impact of BBA on Total Profit Margins:
Hospitals with between 100-200 beds, 1997-2002

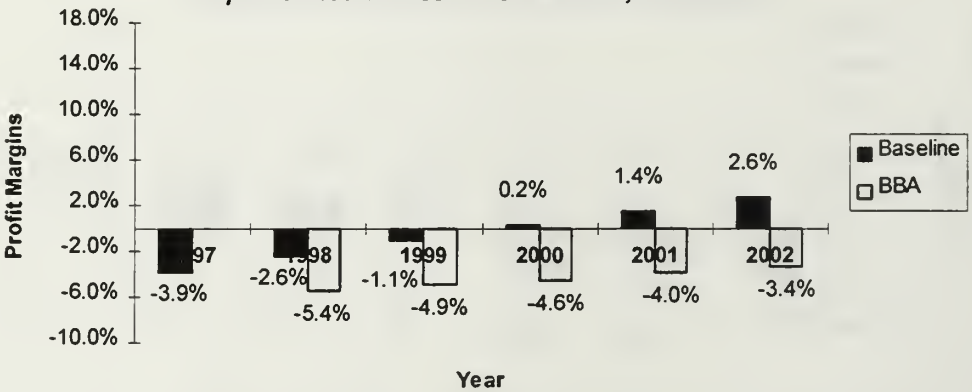

Figure 15.3 C
Impact of BBA on Total Profit Margins:
Hospitals with more than 200 beds, 1997-2002

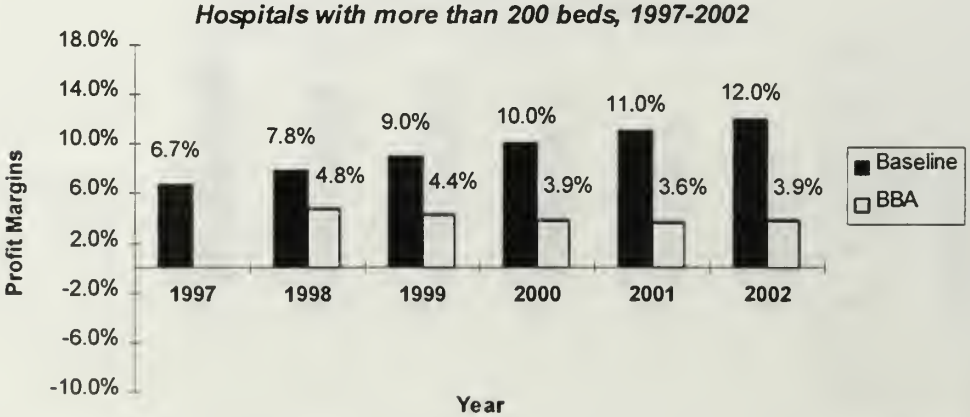

Figure 15.1 D
Impact of BBA on Average Total Profit Margins Weighted by Total Costs: *Hospitals with less than 100 beds, 1997-2002*

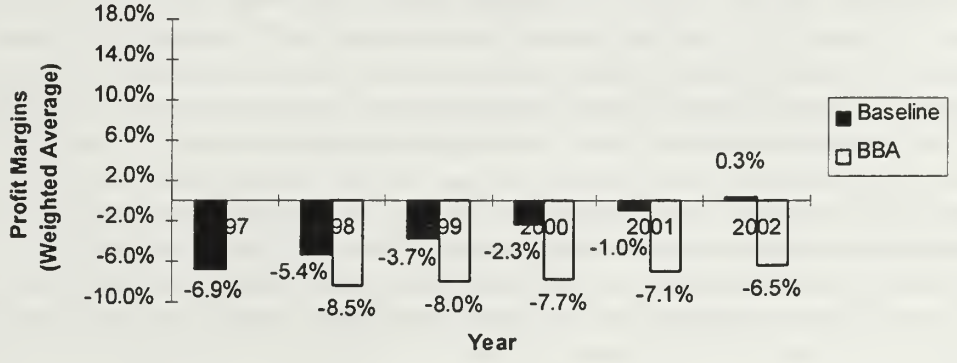

Figure 15.2 D
Impact of BBA on Average Total Profit Margins Weighted by Total Costs: *Hospitals with between 100-200 beds, 1997-2002*

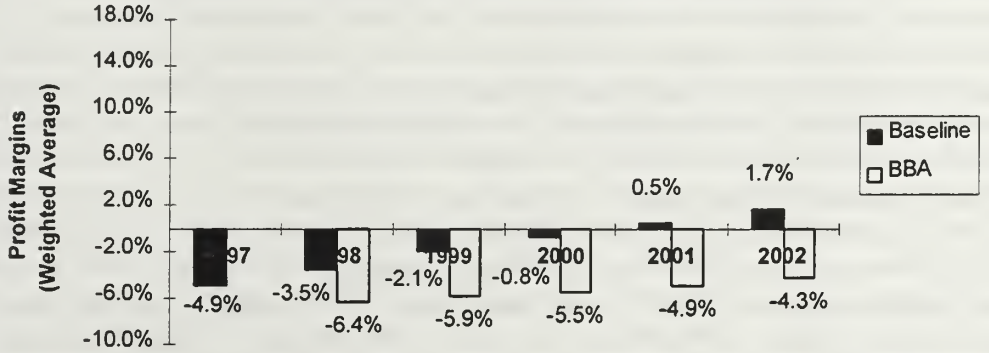

Figure 15.3 D
Impact of BBA on Average Total Profit Margins Weighted by Total Costs: *Hospitals with more than 200 beds, 1997-2002*

Impact on Outpatient Services

When assessing the impact of outpatient PPS on hospitals, it is important to remember that the primary purpose of any prospective payment system is to transfer the risk inherent in the supply of health care services from the payer to the provider.[22] As with inpatient PPS, hospitals will win or lose under APCs depending on their underlying outpatient cost structure which, as shown above, is a function of such factors as location, size, patient population, teaching status, disproportionate share status, and exempted units and services. Low cost hospitals will benefit from outpatient PPS, while hospitals with costs above the mean will lose. Key features in determining how much risk providers will bear under outpatient PPS are: (1) definition of a visit; (2) packaging of medical and ancillary services into APCs; (3) discounting and consolidation of procedures; (4) calculation of weights; and (5) adjustments for cost outliers. Until these issues are resolved, measuring the impact of outpatient PPS on hospitals is impossible.

b. Impact on Medicaid

For hospitals that receive a relatively large proportion of revenue from Medicare, the reductions prompted by the BBA may prompt efforts to recover revenue from other payers. It is unclear whether cost-shifting to Medicaid will be feasible or likely. But if hospitals that are dependent on Medicare also receive a reasonable proportion of their revenues from Medicaid, they may attempt to pursue a cost-shifting strategy with Medicaid. Under a tighter reimbursement regime, hospitals may also be more likely to scrutinize admissions and to engage in up-coding of diagnoses among all patients, including those funded by Medicaid. In addition, since Medicaid programs sometimes model their reimbursement systems on Medicare strategies, it is possible that Medicaid will begin to use a version of the BBA system for inpatient hospital reimbursement. Similarly, other payers may eventually shift to Medicare's APC system. In October of last year, Medicaid began phasing in its own outpatient PPS based on Ambulatory Patient Groups (APGs). The APG system differs from the APC system in several ways, including payment rates and updates, consolidation of procedures, bundling of ancillary services, discounts for additional procedures, and the definition of a payment episode. The implementation of the APC system may influence the design and benefits of outpatient PPS programs ultimately employed by other payers in the state.

c. Impact on Consumers

The PPS provisions of the BBA relating to inpatient services should affect consumers mainly through their impact on the profit margins of community hospitals. As the preceding financial analysis showed, the inpatient provisions of the BBA threaten the already weakened financial viability of many of the state's non-teaching, non-disproportionate share small community hospitals.[23] As their profitability falls, these institutions will face tough decisions regarding the possible elimination of unprofitable services and units. The BBA may also force increasing numbers of these community hospitals in the state to consider options of merger, affiliation, acquisition, conversion or even closure, with serious implications for access to health care in smaller towns far away from the urban centers. Consolidation of hospital services in these areas also raises concerns about competition. Fewer hospitals may lead to higher prices and lower quality. Rate reductions under inpatient PPS may also induce cost shifting to other health care payers with implications for future increases in private insurance premiums,

particularly, but not exclusively, among managed care organizations.

Finally, some of the old concerns raised when Medicare first implemented inpatient PPS in 1983 as a cost containment measure apply here. These concerns relate to hospital incentives to under-treat patients, to actively select profitable admissions, and to dump costly patients on public hospitals.[24] However, given the fact that the BBA lowers the payment rate only marginally in 1998 and thereafter begins to increase it again, risks of patient selection and lower quality are lessened.

Similar concerns arise regarding the consumer effects of outpatient PPS as well. If the outpatient departments of community hospitals are as unprofitable as the inpatient departments appear to be, reductions in payment and/or increases in risk sharing between payers and providers will exacerbate the financial problems with further implications for access among the state's non-urban population. Community hospitals may be forced to eliminate unprofitable outpatient services or, in the extreme, to close outpatient departments all together. Outpatient PPS may induce a shift in patient mix as well as in services. APCs create incentives for hospitals to promote the treatment of low cost profitable patients, while discouraging the treatment of high cost unprofitable patients.

Outpatient PPS raises issues of quality as well. Medicare's APC system creates incentives for hospitals to lower the cost per service and to provide services outside the pre-defined episode of payment. Moreover, the risk of under-treatment rises as the bundling of medical and ancillary services into a single payment category increases. Under limited bundling options, there is pressure to forego those tests that are packaged into a broader payment category (for which no additional payment is received) and to provide only those tests that are not packaged into an APC (for which a separate payment is made). Under complete packaging of ancillary and medical services into APCs, hospitals have an incentive not to provide any tests at all. In such a case, no additional amount is paid for the supply of ancillary and medical tests. The same set of incentives apply with regard to the consolidation of procedures into APCs as well.

5. Summary

Unlike for other providers, the Medicare provisions of the BBA relating to acute care hospitals alter only the marginal rate of payment for inpatient services. Hospitals that were performing well prior to the enactment of the federal legislation should be able to withstand the rate reductions, particularly as payment rates begin to climb again after 1998. Hospitals with low profit margins or whose patient population is composed of a high proportion of Medicare beneficiaries, however, will be the most vulnerable to the marginal cutbacks. Unfortunately, both of these conditions apply to the state's small community hospitals. The large urban teaching and disproportionate share facilities in Massachusetts will have their overall profit margins reduced from approximately 11% in 2002 to 3%. While significantly less than projected profits under previous rates, this is still a viable operating margin. Small community hospitals, on the other hand, will go from earning an estimated 2% profit in 2002 to a 5% loss, with important implications for access among the state's non-urban residents. It remains to be seen whether the implementation of a prospective payment system for hospital outpatient services will

exacerbate the disparity in impacts between community and urban teaching and public facilities.

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[1] Throughout this section, the term 'prospective payment system' (or PPS) is used to describe Medicare's reimbursement system for inpatient general acute care hospital services. The term 'PPS hospitals' is synonymous with non-specialty short-term acute care facilities. As this report makes clear, over the next few years Medicare will begin implementing prospective payment systems for other types of providers as well. In the very near future, it will become necessary to distinguish between inpatient PPS, outpatient PPS, long-term care PPS, home health PPS, etc.

[2] With constant changes through acquisitions, mergers, affiliations and closures, the actual number of acute care hospitals in Massachusetts is a moving target. The number reported here is based on the data given to the Division of Health Care Finance and Policy by the regional HCFA financial intermediaries, the group responsible for administering payment to Massachusetts hospitals.

[3] Quarterly estimates of the PPS hospital input price index used by HCFA to measure cost inflation are published in *Health Care Cost Review* by Standard and Poor's DRG division of the McGraw-Hill Companies in Lexington, MA.

[4] In slight contrast, estimated revenues per discharge at PPS hospitals in Massachusetts increased 2.9% in 1995 and 5.2% in 1996, compared with a 3.1% and 2.8% change in costs for the same two years.

[5] The lower relative outpatient costs may stem from the fact that, since Medicare beneficiaries are probably less likely to seek outpatient care at acute care hospitals, the number of medical and ancillary services provided per visit may be smaller too.

[6] *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission, Washington, DC, March 1998.

[7] One reason for the differential between the national and state averages is the difference in data sets used in each analysis. The national study was based on cost reports hospitals are required to submit to HCFA as part of its payment settlement. As a result, only costs covered by the federal payment guidelines are included. Many non-patient related expenses are not included. The hospital industry has argued that this understates the true cost of providing care to Medicare beneficiaries. In contrast, this analysis is based on cost reports hospitals are required to submit to the state. Since state cost reports include both patient and non-patient related expenses, average costs in the state submission are higher than those reported in the federal submissions. The author felt that the state cost reports provide a more accurate measure of hospital expenditures.

[8] Teaching hospitals were identified by the receipt of payments for indirect medical education from Medicare. Similarly, hospitals with a high share of indigent patients were identified as having received disproportionate share (or DSH) payments from Medicare.

[9] Medicaid uses a much broader definition of DSH hospital to calculate its rate adjustments. To qualify for DSH adjustments under Medicaid, more than 63% of a hospital's total gross patient service revenue must be attributable to Medicare, Medicaid, free care or other government sources.

[10] All patients are classified at discharge into one of 503 diagnostic-related groups (or DRGs). Under PPS, the DRG cost weight acts as the effective 'price' for treating each type of illness and is defined as the average cost of treating the particular diagnosis divided by the average cost of all discharges.

[11] The result of the BBA with regard to reimbursement for inpatient acute care hospital services was to fine-tune the payment parameters. The basic structure of the prospective payment system was left intact. In contrast, the BBA called for fundamental changes in the way in which non-acute care providers (including rehabilitation, chronic care, and skilled nursing units and facilities; long-term care facilities; home health care agencies, outpatient departments and individual physicians) are paid. In most cases, the BBA requires that the Secretary of the Department of Health and

Human Services submit plans for and implement a prospective payment system for these providers.

[12] HCFA uses the PPS market basket projections compiled by DRI as the basis for setting its annual operating updates.

[13] Medicare reimburses hospitals for both indirect and direct medical education expenses. The payment reforms written into the BBA, however, affected only the adjustments for indirect medical education.

[14] The BBA also included payment incentives for hospitals to lower the number of residents.

[15] HCFA recently announced a new interpretation of this requirement that will make it less onerous to hospitals. Under HCFA's new interpretation, only services provided in a hospital that are related to the skilled nursing facility's plan of care are subject to consolidated billing. Non-related services (e.g., a patient in a skilled nursing facility for orthopedic care is admitted to an emergency department for acute myocardial infarction) is not subject to consolidated billing.

[16] For this section of the report, I am indebted to Kevin Quinn, Senior Health Economist at Abt Associates Inc. for information he provided on the design and potential impact of Medicare's outpatient PPS.

[17] Medicare currently uses different versions of cost-based payment methods for hospital outpatient services depending on the type of service. Some services, like clinic and emergency room visits are paid based on the lesser of hospital costs or charges. Pre-approved surgeries are paid the lower of charges, costs, or a blended payment amount that includes the associated ambulatory surgical center rate for the service. Radiology and other diagnostic procedures are paid using a blended payment calculation based in part on the Medicare Fee Schedule for physician services, which varies by hospital type. Clinical laboratory tests and durable medical equipment provided by hospitals are reimbursed under separate fee schedules.

[18] The outpatient PPS affects facility payments only. Physicians will continue to be paid under the existing fee schedule.

[19] Beneficiaries currently pay 20% of billed charges for outpatient services. Because of contractual agreements, beneficiaries pay 50% or more of the total payment for some outpatient services.

[20] The baseline forecasts reported in this section are unrealistically high. Federal lawmakers typically enact HCFA payment regulations for a five year period, with the expectation that future sessions of Congress will amend those regulations downward. Many of the payment regulations used in this section to estimate baseline figures were never meant to be fully implemented.

[21] HCFA's national estimates of the impact of BBA on acute care hospitals are based on a similar assumption regarding cost inflation. According to estimates published by Standard and Poor's DRI, PPS input prices have increased nationally on average 2.9% per annum over the past five years.

[22] Since the APC system is intended to be budget neutral based on projected payments in 1999 under the current fee schedule, hospital revenues on average should remain unchanged. However, as the BBA illustrates, prospective payment systems make it easier for Medicare to cut expenditures simply by lowering the annual update factor or adjusting downward one of several other key payment parameters. The budget neutrality condition during the phase-in period should not lull hospitals into a false sense of stability.

[23] Out of the 18 small acute care hospitals (facilities with less than 100 beds) included in this analysis, 12 reported incurring total losses in 1996. Of these, only three received either IME or DSH adjustments from Medicare.

[24] Evidence for the effects of PPS on patient quality and access has been amply documented in the health services research literature over the past 15 years. In fact, many subsequent refinements to inpatient PPS (e.g., the introduction of procedure-based DRGs) represent direct attempts to correct incentives to lower the quantity of care inherent in the original system.

Section B: PPS-Excluded Hospitals

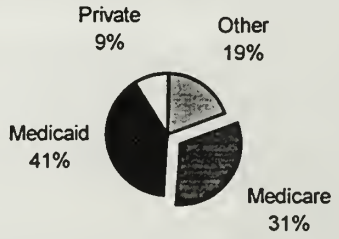
1. Status of the Industry in Massachusetts

When the Prospective Payment System (PPS) was established for hospitals participating in the Medicare Program in 1983, certain facilities were excluded from the PPS system. The exemption was primarily due to the inability to apply the DRG patient classification system to patients with specific types of diagnoses, who are admitted to specialized inpatient facilities. Because of this specialization, there was not an appropriate classification tool or the ability to identify variations or patterns in resource use among these specialized facilities. [1]

There are currently 51 specialty hospitals (children's, cancer, rehabilitation, psychiatric, chronic and state-run facilities) that are eligible for PPS-excluded status in the Commonwealth of Massachusetts. With the exception of Children's Hospital and the Dana Faber Cancer Institute, these specialty facilities are referred to as non-acute hospitals. In addition, in 1996 there were 5 rehabilitation and 44 psychiatric distinct part units in acute care hospitals that were reimbursed by Medicare through the PPS-excluded system. Medicare revenue to all PPS-excluded facilities in Massachusetts was over $246 million. Ninety-four percent of the payment was for operating costs while capital reimbursement made up the remaining 6%.

In 1996, Medicare patients utilized over 32,000 days or 61% of the occupancy in the rehabilitation units and over 143,000 days or 44% of the occupancy in the psychiatric units. Utilization by payer type for all non-acute hospitals is shown in Figure 16.

Figure 16:
Utilization by Payer
FY 1996



In order to seek exclusion from the prospective payment system, a rehabilitation hospital or unit in an acute care hospital must demonstrate that at least 75% of its patients require intensive rehabilitation services for a number of treatments or conditions.[2] A psychiatric hospital or distinct part unit must treat patients whose principle diagnosis is a psychiatric disorder which can include alcohol and drug-related problems. A chronic or long-term care hospital serves the chronically ill patient whose

average length of stay is greater than 25 days. There are also additional requirements that Medicare certified facilities must satisfy to qualify for PPS exclusion[3].

The payment system for these facilities, excluded from prospective payment, was expected to be a temporary reimbursement solution under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). In 1982, these facilities represented only a small portion of Medicare inpatient discharges and patient care costs. However, this group of service providers has steadily grown over the intervening years. Massachusetts Medicare utilization of them in 1996 was very similar to national trends with over 8% of total Medicare discharges and slightly over 10% of Medicare cost occurring in them.

2. Current Reimbursement Strategies

The TEFRA payment methodology establishes a target or ceiling that consists of base year allowable Medicare inpatient operating cost (excluding capital and medical education costs) per discharge. The target is subject to annual updates that are tied to Market Basket inflation for PPS-excluded Hospitals. The PPS-excluded base year for hospitals is the second full year of reported cost while the base year for distinct part units is the first full year of reported costs.[4]

Facilities that spend less than their target amount per discharge receive a bonus or incentive payment that is the lesser of 50% of the difference between its cost and the TEFRA target amount, or 5% of the target amount. For example, a hospital (below target) whose Medicare inpatient operating cost was $2,000 per discharge and whose target was $3,000 per discharge would receive an additional $150 per discharge, for a total of $2,150. In this example, 5% of $3,000, or $150, is the bonus payment since this amount is less than $500, which is half of the difference between cost and the target amount.

The Omnibus Budget Reconciliation Act (OBRA) of 1993 affected 1994 to 1997 reimbursement to PPS-excluded facilities by reducing HCFA market basket updates by 1%. Hospitals with 1990 operating cost over target by 10% or more were exempt from the 1% reduction. Hospitals over target up to 10% could have the update factor reduced less than 1%. These hospitals would receive a reduction to the update factor of the lessor of 1% or the difference between 10% and the actual percentage over target.

TEFRA authorized the Secretary of HHS to allow annual adjustments for costs beyond a facility's control. Adjustments can range from a one time correction to a permanent adjustment to a provider's base year target. OBRA of 1990 allowed facilities to re-base if there were substantial and permanent changes to patient service.

TEFRA payment exceptions are allowed for the following:

- Changes in applicable technology or medical practice, or increases in severity of illness that increase cost;
- Increases in wages and wage-related cost in the geographic area of the facility that exceed the national average increase in hospital wages; or
- Changes in other factors that the Secretary considers sources of appropriate increases in a provider's allowable cost.

TEFRA providers are the only facilities that were reimbursed for Medicare capital at the facilities' reasonable cost. This policy was one way that newer facilities were able to outmatch payments to older facilities. Of approximately $13.6 million that Medicare spent on capital payments to Massachusetts excluded hospitals in 1996, one private psychiatric hospital alone received close to $2,600 per discharge payment for capital while many other hospitals receive no additional payment for capital.

Table 3 below shows the historical changes to the TEFRA payment system.

Table 3

Historical Changes to the TEFRA Payment System

Time Period	Cost in Relation to Target per Discharge:	Payment	Bonus	PPS-Excluded Average Update Factor:
1983 – 1984	< 100%	Actual cost	Lesser of 50% of difference between cost and target or 5% of target	Market Basket
	100%	Target amount		Market Basket
	> 100%	Target plus 25% of difference between the target and the actual cost		Market Basket
1985 – 1991	< 100%	Actual cost	lesser of 50% of difference between cost and target or 5% of target	Market Basket
	100% or more	Target amount		Market Basket
1992 – 1993	< 100%	Actual cost	lesser of 50% of difference between cost and target or 5% of target	Market Basket
	100% - 110%	Actual cost		Market Basket
	110% or more	Target amount plus 50% of cost exceeding the target (not more than 110% of target)		Market Basket
1994 – 1997	< 100%	Actual cost	lesser of 50% of difference between cost and target or 5% of target	Market Basket minus 1%
	100% - 110%	Actual cost		Market Basket minus 1%
	110% or more	Target amt plus 50% of cost exceeding the target (not more than 110% of target)		Market Basket minus 1%

3. Changes as a Result of the Balanced Budget Act

The BBA introduced many changes to the formula used to reimburse non-acute hospitals in an effort to gain more control over the growth of program costs for these facilities. Ten specific changes are identified and briefly discussed in this section.

a. Average Update Factor

As detailed above, in 1994 HCFA modified TEFRA targets to excluded providers by allowing full market basket updates only when operating costs exceeded targets by 10% or more. As a result of the BBA, in 1998, all hospitals will receive zero percent update to their target amounts. Moreover, for years 1999 through 2002, the HCFA market basket updates will again be modified based on the facility's actual operating cost. Table 4 below shows the BBA provisions from 1998 to the year 2002.

Table 4

Medicare Provisions of the BBA Relating to Non-Acute Hospitals

Time Period	Cost in Relation to Capped Target per Discharge:	Payment	Bonus		PPS-Excluded Average Update Factor:
1998	< 100% or 100%	Actual cost	lesser of 15% of diff. bet. cost and target or 2% of target	plus: 50% of current cost and expected cost up to 1% of target	0%
	100% - 110%	Target			0%
	110% or more	Target amt. + 50% of cost exceeding 110% of target (up to 110%)			0%
1999-2002	< 66%	Actual cost	Lesser of 15% of diff. bet. cost and target or 2% of target	Plus: 50% of current cost and expected cost up to 1% of target	0%
	66% - 100%	Actual cost	Also eligible for bonus payments above.		The greater of Market Basket minus 2.5% or 0%
	100-110%	Target			Market Basket
	110% or more	Target amt. + 50% of cost exceeding 110% of target (up to 110% of target)			Market Basket

b. Caps on Target Amounts for Excluded Hospitals and Units

In addition to limits on the average update factor, excluded hospitals will have new caps on target reimbursement levels under the BBA. Excluded hospitals and units will be limited to a cap on their target amounts based upon the 75th percentile of the median class target for the cost reporting period ending in 1996. The per discharge target amounts are:

- Psychiatric hospitals and units $10,188
- Rehabilitation hospitals and units $18,476
- Long-term care hospitals $36,449

c. Bonus Payments

Applied to the current methodology of rewarding hospitals that have operating costs below their targets, the new law reduces the TEFRA bonus payments. A hospital that has operating costs below its target will be paid cost per discharge plus the lower of 15% (instead of 50%) of the difference between its operating cost and the target or 2% (not 5%) of its ceiling.

To reward efficient providers, the law also provides a "continuous improvement bonus" for hospitals with PPS-excluded experience for three years prior to the current year. These hospitals must have operating costs for the current period below the lower of the target amount, the trended cost[5] or the expected cost[6]. These hospitals would receive a payment equal to the lower of 50% of the difference between the expected cost and actual operating costs or 1% of the target.

d. Relief Payments

The BBA amends OBRA of 1990 by making relief payments available to hospitals with operating costs over 110% of their targets. For this group of hospitals, the payments are 50% of the difference between the actual cost and 110% of the target ceiling not to exceed 10% of the target. Exceptions to TEFRA payments will not encompass costs within 110% of the ceiling.

e. Choice to Re-base

During 1998, qualified hospitals and distinct part units that were PPS-excluded providers prior to 10/1/90 may elect to re-base their target amounts for the cost reporting period. The methodology will consist of selecting the average of three years updated cost per discharge of the latest five years of settled cost reports (as of 8/5/97) after excluding the highest and lowest unit cost from the group. The revised target amounts will be subject to the same threshold provisions for new hospitals described below.

The law also states separate re-basing provisions for certain long-term care hospitals. These would affect hospitals with Medicare cost over 115% of the target and hospitals that had a 70% disproportionate patient population according to PPS rules. These hospitals may select their 1996 cost per discharge with a 2.5% Market Basket update to 1997, subject to a threshold provision for new hospitals described below. The target will be inflated to the current year with Market Basket updates for 1999 through 2002.

f. Revised Allowable Capital Costs

From 10/1/97 through 9/30/02, the amendments require new reductions to capital reimbursement for PPS-excluded providers. Capital reimbursement to excluded providers will be limited to 85% of reasonable costs.

g. New Providers

The BBA requires a ceiling for TEFRA targets for new Medicare providers of psychiatric, rehabilitation long-term care and cancer hospitals or units on or after 10/1/97. This provision replaces the practice of paying PPS-excluded providers at cost until their targets are determined. The base period will remain the same but the target ceilings will be the lesser of the base period actual operating cost or 110% of the 1996 national median updated and adjusted for wage area differences for the same class of hospitals.

New provider target amounts for 1998 are:

- Psychiatric hospitals and units $ 8,203
- Rehabilitation hospitals and units $16,129
- Long-term care hospitals $18,324

h. New Criteria for Excluded Hospitals and Units Within Hospitals

Beginning in 10/1/97, hospitals and units within hospitals are subject to new rules for exclusion from the prospective payment system. Distinct and separate control from the hospital sharing space will be required of the hospital governing body, the chief medical officer and the chief executive officer.

Long-term care hospitals classified prior to 9/30/95 and hospitals that received payments in 1986 with lengths of stay greater than 20 days and 80% or more of its discharges classified as neoplastic disease during the year's cost reporting periods ending with 1997 are exempted from these provisions.

i. Reporting Provisions

The Secretary is required to report and publish in the Federal Register all adjustments made to excluded hospitals and units during the prior fiscal year. This provision will enable data collection and analysis of true payment levels for this sector of the industry.

j. PPS for Rehabilitation Hospitals and Units

Excluded rehabilitation hospitals and units will begin a phase-in of a prospective payment system for operating and capital expenses beginning on or after October 1, 2000 with full implementation in 2002. Beginning with FY 2001, the law requires the Secretary to publish on or before August 1 of each fiscal year the classification and weighting tools for case mix groups with a description of the data and methodology used in the computation of rates. The PPS payment methodology must be budget neutral during 2001 and 2002. Additionally, the Secretary is required to submit to Congress a proposal for a prospective payment system for Long-term care hospitals by 10/1/99.

4. Impact of the Balanced Budget Act

a. Impact on Providers

HCFA estimates that the net effect of the BBA changes to PPS-excluded hospitals will be approximately a 1% decline in per admission reimbursement. In addition to an attempt to slow the overall increase in Medicare cost, there are measures within the amendments to remedy some of the inequities among new and old providers as well as to limit the proliferation of this group of hospitals and distinct part units.

On average, in 1996, rehabilitation hospitals in Massachusetts were reimbursed at their cost and their payments fell well below Medicare target ceilings set for them. Psychiatric facilities received payments that averaged 22% below their targets. Medicare payments to chronic care facilities were about 2.5% over their target ceilings.

In Massachusetts, the average target for chronic hospitals is well below the 1996 median class target of $36,449, and their average cost is above the median class target at $40,422 (see Table 5). Therefore, Massachusetts chronic hospitals may choose to re-base their payments. The ability to utilize the average of costs over multiple years should mitigate any volatility from atypical years.

Table 5:

Average TEFRA Targets, Medicare Payments and Cost Per Discharge for Massachusetts Providers: 1996

Type of Hospital	Average TEFRA target	Average Medicare Payment (Excl. Capital)	Average Cost per Discharge (Excl. Capital)
Psychiatric	$15,205	$8,667	$19,039
Rehabilitation	$15,457	$12,964	$12,783
Long Term Care (Chronic)	$14,075	$15,041	$40,422

Effects of reduced capital payments are as idiosyncratic as the industry itself. Medicare payments to Massachusetts hospitals in 1996 were approximately $13.6 million. The BBA mandated reduction in capital costs of 15% amounts to a loss of over $4 million in revenue. Hardest hit will be three Massachusetts hospitals that receive over $150 a day in capital reimbursement.

b. Impact on Medicaid

Inpatient reimbursement to non-acute hospitals by the Medicaid program is subject to an upper limit that is measured by Medicare reimbursement principles. Medicare cutbacks caused by the 1998 freeze in operating cost and reductions in capital as well as future provisions will impact Medicaid's reimbursement ceilings. The implications of lower Medicare reimbursement need to be carefully monitored for

Medicaid compliance to upper limit requirements and should reduce flexibility in the rate setting process. Along with the repeal of the Boren amendment, the impact of lowering the Medicare upper limit will prove another cost effective measure for Medicaid reimbursement to PPS-excluded facilities and units.

Simultaneous changes in reimbursement policies by both Medicare and Medicaid will undoubtedly magnify the impact of the BBA on hospitals excluded from PPS. These facilities may experience a significant total reduction in revenue, which may translate into reductions in staffing, efforts to improve efficiency of service delivery and efforts to shift costs to other payers.

In addition to these issues, the Medicare patient that is dually eligible for Medicaid may present an additional cost to the Medicaid program. Since it is estimated that close to 75% of Medicare patients in chronic and rehabilitation hospitals fall into this category, the amount that Medicaid spends on co-payments and deductibles may increase.

c. Impact on Consumers

National estimates of five-years savings from PPS-excluded hospitals amounts to $4 B[7]. The chronic and rehabilitation hospitals that are most greatly affected by reduced Medicare revenue will inevitably resort to shortening lengths of stay in their facilities, thus putting greater pressure on skilled nursing facilities and home health care alternatives. Psychiatric facilities will also be pressured to discharge patients into the community at much faster rates. As the incentives to discharge patients grow, the effects of payment reductions in patient care may cause quality as well as access problems for the patient with relatively greater complexity of care. Until the prospective payment system with case-mix indicators for PPS-excluded facilities is fully implemented, questions about quality and access will not be able to be answered.

5. Summary

The complexity of Medicare reimbursement to PPS-excluded facilities is largely due to the heterogeneity among hospitals as well as in the range of patients and their care. Disparities in many hospital characteristics, such as age of facility, average length of stay, type of patient treated, has made movement towards a prospective payment system very difficult.. While we are able to show average Medicare payments and cost per discharge, the considerable variation from facility to facility in Massachusetts must be emphasized. It is difficult to assess the overall impact of these changes on PPS-excluded facilities in Massachusetts, as a whole. Children's Hospital and the Dana Faber Cancer Institute[8] will largely remain unaffected by the BBA changes and are not subject to the target caps.

The already intricate system under the BBA will increase in complexity with new thresholds for differential updates, an additional incentive mechanism, new opportunities to re-base, limits on capital pass through and caps on operating cost TEFRA targets. The phase-in of the prospective case-mix payment system for rehabilitation hospitals and units beginning in the year 2000 to be fully implemented in 2002, will resolve many of the issues concerning payment equity for these facilities. In Massachusetts, it is possible that Medicare reform will eventually affect two thirds of hospital TEFRA

payments by the turn of the century.

References:

42 C.F.R. § 412.23

Public Law 103-66, Section 13502.

Congressional Report C-92-05, Prospective Payment Assessment Commission, Interim Report on Payment Reform for PPS-Excluded Facilities. (Washington DC: October 1992).

Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy,* Vol. I and Vol. II, (Washington, D. C: May 1998).

Smith, Sheila D. *The Balanced Budget Act of 1997*, Standard & Poor's DRI Health Care Cost Review, Third Quarter 1997.

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[1] In studies of rehabilitation facilities conducted by the Rand Institute and Tufts University, patient severity of illness was the most significant predictor of charges, but a patient's functional status at admission was equally important.

[2] Conditions to qualify for rehabilitative services are stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, polyarthritis (including rheumatoid), neurological disorders (multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, Parkinson's disease) and burns.

[3] Distinct-part units must have separately identifiable admission and discharge records as well as state licensure laws, in addition to physically separated beds.

[4] In C-92-05, PROPAC reports that hospital base years were established using either the first or third full year of cost following initial certification.

[5] Trended cost is the lesser of the actual operating cost or the target amount in 1996 updated by the Market Basket to current year.

[6] Expected costs is the lesser of the actual operating cost or target amount for the previous cost reporting period updated by the current year's Market Basket inflation.

[7] Congressional Budget Office, July 1997.

[8] 42 C.F.R. § 412.23(f). Legislative mandate provided that all additional cancer hospitals be classified as excluded by 12/31/91.

Section C: Nursing Facilities

Since 1986, federal Medicare spending for nursing facility care has increased, on average, by approximately 35% annually[1]. This increase has prompted Congress to implement tighter cost controls on nursing facilities as part of the Balanced Budget Act of 1997 (BBA). The Congressional Budget Office estimates that the provisions of the BBA will reduce Medicare expenditures on nursing facility care by approximately $9.5 billion[2] over the years 1998-2002. In order to achieve these cost reductions, Congress has mandated that HCFA move the current Medicare payment system from a primarily cost-based reimbursement system to a prospective payment system.

We are unable to estimate the specific fiscal impacts for the nursing facility industry. Congress instructed the Health Care Financing Administration (HCFA) to specify the details of the prospective payment system by May 1, 1998. No specific payment rates will be established until HCFA releases its regulations. Without the payment rates, we cannot project the financial impact on nursing facilities. We can, however, identify the facilities that are most financially dependent on Medicare, and those facilities that will face the most financial pressure as a result of the BBA.

1. Status of Industry in Massachusetts

Not all nursing facilities in the Commonwealth are licensed to treat Medicare patients. In 1996, approximately 88% of the freestanding nursing facilities in Massachusetts treated Medicare patients[3]. Medicare pays for skilled nursing and rehabilitative care, but does not cover custodial care. Since patients in a Medicare unit of a nursing home require more skilled nursing care than other residents, nursing facilities typically have a distinct Medicare unit within the facility. Nursing homes usually staff these units with a higher skill mix of staff. This varied skill mix often results in higher costs for those facilities with a higher than average percentage of Medicare patients.

Since Medicare pays only for the first 100 days of nursing facility care, Medicare usually does not cover an entire nursing facility stay for a patient. After Medicare no longer covers the patient's stay, the patient will generally turn to private sources of payment to pay for his care. Once these private sources are exhausted, Medicaid will usually pay for the remainder of the stay.

Figure 17: Payment for a typical nursing facility stay

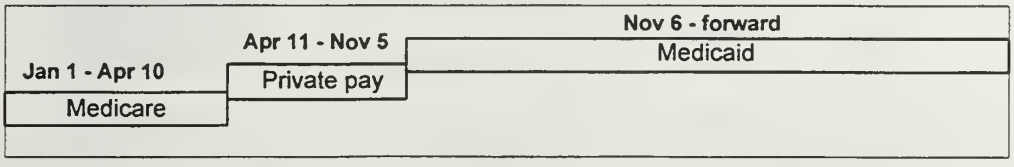

Figure 17: Since Medicare pays for only 100 days of skilled nursing care, most residents eventually rely on private sources and Medicaid to pay for their care.

In Massachusetts, Medicare costs and utilization in nursing facilities have increased significantly over the past seven years. Figure 18 shows the increase in the share of Medicare days out of the total skilled nursing days in Massachusetts.

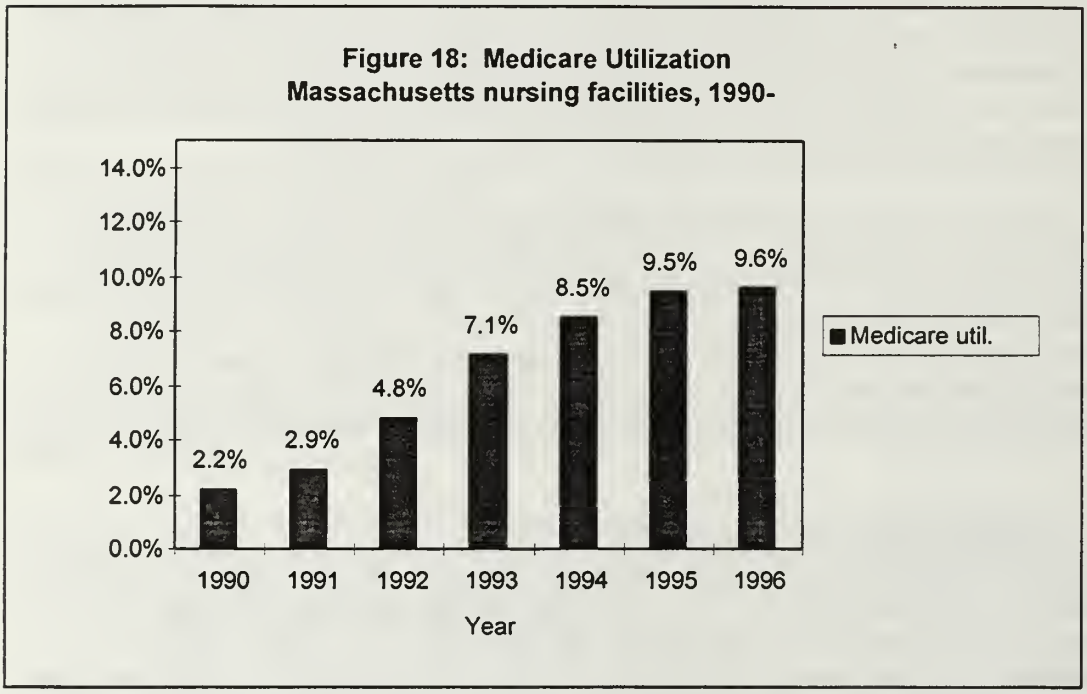

Figure 18: Since 1990, Medicare has paid for an increasing share of the patient days in nursing homes.

This large increase in utilization, in tandem with increases in the level of Medicare payments, has resulted in an increase of total Medicare revenue to Massachusetts nursing facilities from $43.2M in 1990 to $363.2M[4] in 1996. As is indicated in Figure 19, Medicaid remains the largest payer for skilled nursing services in Massachusetts.

Figure 19:
Utilization by payer, Massachusetts nursing homes
1996

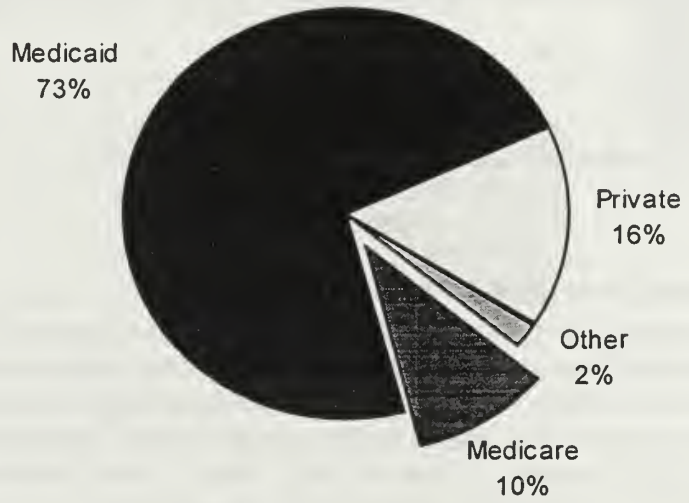

Figure 19: The state Medicaid program is the primary payer for skilled nursing services in Massachusetts.

However, some facilities are more dependent on Medicare revenue than others. For instance, not-for-profit facilities serve, on average, a higher proportion of Medicare beneficiaries. (see Table 6).

Table 6

Utilization at free-standing facilities, for-profit vs. not-for-profit [5]

	Number of facilities	Medicare Utilization	Medicaid Utilization	Private Utilization	Other Utilization
For-profit	379	8%	75%	14%	3%
Not-for-profit	133	13%	67%	19%	1%
All facilities	512	10%	73%	16%	2%

One group of facilities in particular that is very dependent on Medicare revenue is hospital-based transitional care units (TCUs)[6]. Hospital TCUs are units within the hospital that have been converted specifically to treat post-acute patients. The Medicare reimbursement system has encouraged the growth and expansion of the hospital-based TCU market. In 1992, there were 5 hospital based TCUs in Massachusetts. In 1997, the number had grown to 36[7].

Table 7
Utilization, hospital-based TCUs vs. free-standing SNFs

	Number of facilities	Medicare Utilization	Medicaid Utilization	Self pay & other Utilization
Hospital based TCUs	36	92%	1%	7%
Freestanding SNFs	512	10%	73%	18%

2. Current reimbursement strategies

For the routine services of the Medicare bill, such as room and board and skilled nursing services, the federal government pays nursing homes a per diem rate, based on facility-specific per diem costs, subject to national average caps. In addition, certain ancillary services provided by staff of the nursing facility, such as therapy services, are paid on a facility-specific cost basis, with no limits. Most ancillary services are provided by ancillary providers who bill Medicare directly for these services. This system has created little incentive for nursing facilities to contain ancillary costs, and has resulted in a large increase in Medicare expenditures for skilled nursing services. In 1984, payments for skilled nursing facility care accounted for 1 percent of total national Medicare outlays. By 1996, skilled nursing facility outlays accounted for 6 percent of total Medicare outlays[8]. Much of this increase is attributable to increases in payments for ancillary services, while part is due to a large increase in utilization. Since 1992, the number of Medicare funded nursing facility residents nationally has increased nearly 10% annually.[9] This increase is due partly to an aging population, but is also due to Medicare's more generous reimbursement when compared with Medicaid programs.

3. Changes as a result of the Balanced Budget Act

In an attempt to contain these increased costs, Congress has mandated that Medicare move away from this cost-based reimbursement system toward a prospective system. A prospective payment system will give nursing facilities a fixed payment rate that is expected to cover all the nursing home services, both routine and ancillary. The implementation of PPS can be divided into three stages: data collection, Part A prospective payment, and Part B consolidated billing. Each of these changes is discussed below.

a. Data collection

Congress mandated that the prospective payment system include an adjustment for case-mix. The case-mix adjustment would adjust the payment level for the varied types of functional dependence, illness severity, and resource use of different patients. Although Congress did not mandate a specific case-mix adjustment system, it is very likely that HCFA will choose the Resource Utilization Group System, version III (RUGS-

III). The RUGS-III model uses information gathered on individual patient specific surveys, called the Minimum Data Set (MDS). The MDS assesses a patient's functional status, with measures for the patient's cognitive ability, communication patterns, and physical functioning. The RUGS-III uses the MDS data to group patients into 44 resource groups, similar to Diagnostic Related Groups (DRGs) for acute hospital inpatients. HCFA has been running demonstration projects in 6 states using the RUGS-III model for Medicare nursing facility reimbursement.

HCFA has mandated that nursing facilities begin submitting electronic MDS information beginning June ,1998 to the state data collection agencies. In Massachusetts, the Department of Public Health (DPH) is responsible for collecting the MDS data from the facilities, and submitting the information to Medicare. Nursing facilities must complete MDS surveys for all patients at regular intervals during the patient's stay. Nursing facilities have been collecting paper versions of MDS data and submitting information in aggregate to DPH for several years. These data have been used for patient-level quality audits during each facility's regular inspection by DPH. There will be an advantages to having a single data collection system used in facilities for both reimbursement and quality improvement. There won't be an incentive to upped for reimbursement if there are penalties on the quality side.

b. Part A Prospective Payment

As described above, Medicare pays nursing facilities a per diem rate that covers the routine and skilled nursing portion of a Medicare resident's bill. This payment is currently derived from facility-specific costs, subject to national caps. Under prospective payment, the per diem payment will eventually be based on a federal standard amount. HCFA will adjust this federal standard amount for variation in case-mix and regional cost differences. The federal per diem will include costs for capital, routine, and ancillary services, plus an amount added for Part B ancillary services. The federal per diem will be inflated by the HCFA skilled nursing market basket minus 1% in 1998, and the full market basket in succeeding years.

The prospective payment system (PPS) will begin with the cost reporting period beginning on or after July 1, 1998. For most Massachusetts facilities, this means that prospective payment will begin on January 1, 1999, although a handful of facilities will begin sooner. For most facilities, the PPS will be phased in over 4 years, with a blend of the federal and facility specific payment rate. Figure 20 indicates the transition from the facility-specific rate to the federal rate. HCFA will base the calculation of both the federal and facility-specific rates on 1995 cost report data. New facilities, or facilities that do not have cost data from 1995, will be moved directly to the federal payment rate.

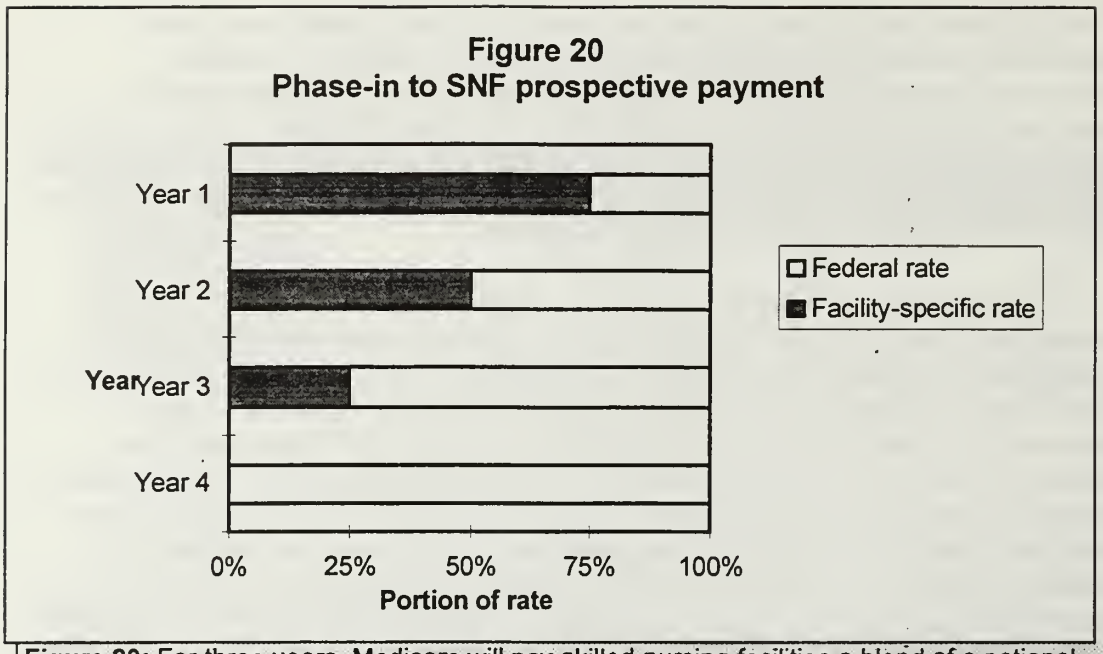

Figure 20: For three years, Medicare will pay skilled-nursing facilities a blend of a national standard per day payment and a facility-specific per day payment.

c. Consolidated Billing for Part B Services

The final part of the prospective payment system is a change in Medicare's payment for ancillary services paid for under Medicare Part B. These ancillary services include physical and occupational therapy, hearing aids, prescription drugs, dental services, as well as other medical services. Presently, when a Medicare funded nursing facility resident receives ancillary services, the ancillary provider bills Medicare directly. For instance, if a patient is sent to a hospital for a CAT scan, the hospital bills Medicare under Part B for these services. While the current system is administratively simple, it provides little financial incentive for a nursing facility to monitor and contain the costs for ancillary services. As part of the BBA, Congress is revising this system to make the nursing facilities financially accountable for a large amount of the ancillary expenses.

Under the consolidated billing provisions of the BBA, nursing homes will receive an add-on for most Medicare Part B ancillary services. Ancillary providers will bill the nursing facility directly for these services, and the facility will be responsible for paying the ancillary provider. For hospital services, only those services that are related to a patient's normal plan of care will be subject to consolidated billing. Emergency services provided to a SNF resident will therefore be exempt from consolidated billing. Congress excluded some other services, noted in Figure 21, from the consolidated billing provisions.

Figure 21

Part B Services Excluded from Consolidated Billing

- **Physician's services**
- **Physician Assistants working under a physician's supervision**
- **Nurse practitioners and clinical nurse specialists**
- **Certified nurse mid-wives**
- **Qualified psychologists**
- **Certified registered nurse anesthetists**
- **Home dialysis and supplies**
- **Transportation costs of electrocardiogram equipment for electrocardiogram test services (1998 only)**
- **Services for any patient in a non-Medicare certified facility**

Consolidated billing is scheduled to begin July 1, 1998. However, HCFA implemented a transition period from July 1, 1998 through December 31, 1998. During this period, facilities are expected to develop the systems and operational capacity to implement consolidated billing. During the transition period, ancillary providers will continue to bill the Medicare Part B intermediary. The Part B consolidated billing will therefore be in effect for most providers beginning January 1, 1999.

4. Impact of the Balanced Budget Act

a. Impact on Providers

Nursing facility administrators will likely respond to declining Medicare revenue by reducing costs at their own facilities. In addition, before the BBA there was no incentive for the facility to manage ancillary costs. Ancillary providers are also directly impacted by the consolidated billing provisions. Nursing homes will be applying increased pressure on these ancillary providers to contain costs and to justify services to patients. In addition, since nursing homes will now be paying ancillary providers, some ancillary providers are worried that the nursing facilities will make payments less quickly than the Medicare program.

The BBA also adds operational burdens to nursing facilities. The new consolidated billing system requires facilities to develop internal systems for the disbursement of Medicare payments to ancillary providers. The facilities will also monitor ancillary utilization and quality more closely. For some facilities, moving to electronic submissions of MDS data will be an added expense, albeit a minor one. HCFA estimates that the added cost of implementing the MDS system for an average nursing facility will be an approximate initial expense of $3,800, and added annual expenses of about $1,700[10].

Generally, the larger for-profit nursing facilities will weather these changes more

successfully than the smaller independent nursing facilities. The larger facilities in the state, especially those owned and operated by for profit chains, often own ancillary providers or will have the market clout to negotiate lower cost contracts. The larger facilities will also be able to alter their operations more easily than the smaller facilities to respond to the demands of consolidated billing.

In particular, hospital TCUs are very vulnerable to the changes implemented under the BBA. This vulnerability is attributable to three factors. The first factor is their dependence on Medicare revenue. In 1996, Medicare utilization in TCUs was nearly 92%, compared with the approximately 10% Medicare utilization in freestanding facilities[11]. The second factor is the timing of Part A prospective payment. The base per diem rate used under Part A prospective payment will be based on 1995 cost report data. Many Massachusetts TCUs do not have cost data from 1995. In these cases, Medicare will pay the facility the federal rate, commencing with the first cost reporting period after July 1, 1998. The TCUs will therefore have less time to reduce their costs in anticipation of prospective payment. The third factor is a change relating to transfer payments for acute hospitals. In the BBA, Congress redefined the movement of some patients from acute hospitals to post-acute providers as transfers, instead of discharges, for 10 groups of diagnoses. Congress required HCFA to specify which 10 groups these will be, and HCFA is permitted to increase the number of groups beginning on October 1, 2001. This change effectively reduces hospital payments for patients in these groups if the hospital transfers the patient early to a nursing facility, rehabilitation hospital, hospital TCU, or to the care of a home health agency. This policy will eliminate the incentive to transfer patients out of the acute setting and into a post-acute setting earlier than usual in order to maximize reimbursement. There is some evidence to suggest that hospitals owning hospital-based SNFs are transferring patients out of the acute setting into a post-acute setting in order to maximize federal reimbursement[12]. In response to this policy change, hospitals are expected to reduce transfers to post-acute settings for the selected groups of patients. As a result, admissions to post-acute care facilities, and hospital TCUs in particular, will likely be reduced.

These three changes will have a significant impact on hospital TCUs. It is likely that some hospitals will choose to exit the TCU market completely, resulting in closures of some TCUs. If this occurs, admissions to freestanding skilled nursing facilities and rehabilitation hospitals will increase.

b. Impact on Medicaid

The BBA mandated reductions in home health reimbursement may result in increases in admissions to nursing facilities. For some less severely ill patients, home health services are a substitute for long-term care services[13]. If, in reaction to Medicare payment reductions, home health agencies curtail services to Medicare patients, we can expect an increase in admissions to skilled nursing facilities. Ultimately, the state Medicaid program will likely assume many of these increased admissions and costs.

Furthermore, we can expect that the payer-mix within nursing facilities will be altered. The growth in Medicare utilization in nursing facilities is expected to decline, or, at the very least, stabilize at current levels. In fact, the rapid growth of Medicare utilization appears to have slowed down in recent years. As is indicated in Figure 18,

Medicare utilization in Massachusetts nursing facilities was relatively constant in 1995 and 1996. If reimbursement for Medicare residents is sufficiently constrained, facilities may increase admissions for Medicaid patients.

c. Impact on Consumers

Consumers of nursing facility services are typically most concerned with access to the appropriate level of care and the quality of the care. In terms of access, the BBA is unlikely to hinder overall admissions to nursing facilities. There is currently no shortage of nursing facility beds in Massachusetts. However, some facets of the BBA may provide incentives for nursing facilities to curtail some types of services currently provided.

One issue to monitor closely is admissions for particular types of patients. If HCFA selects the RUGS-III system, as is expected, the level of rates that HCFA establishes may provide incentives for facilities to admit one type of patient over another. For example, the RUGS-III model pays more for patients who require complex rehabilitation, and it pays less for patients who have primarily cognitive impairment and behavioral problems. Facilities may therefore decide to minimize admissions of patients with cognitive impairment in favor of rehabilitation patients. However, the particular incentives provided, and which patients will be more profitable to the facilities, will not be readily identifiable until after HCFA establishes the rates. Close monitoring of admission and treatment patterns is therefore warranted.

The BBA encourages nursing facilities to place greater controls on ancillary services. While these controls may reduce costs, significant reductions in ancillary services may hinder the quality of patient care. For instance, laboratory tests to test patients' medication levels may be done less frequently, or specific types of durable medical equipment may be replaced with less costly equipment. In addition, the National Association of Social Workers (NASW) has expressed concern that clinical social worker services will be affected. These social workers often provide mental health therapy and counseling to nursing facility residents. These services are usually different from social work services provided by the nursing facility staff. If nursing facilities choose to eliminate clinical social work services completely, the quality of patient care will suffer. Nursing facilities may, however, replace clinical social workers with psychologists and psychiatrists. Congress specifically exempted both psychiatrists and psychologists from consolidated billing, so they may bill Medicare directly, at no additional cost to the nursing facility.

The BBA may induce positive changes in the quality of patient care, primarily as a result of the new mandate to electronically submit the Minimum Data Set (MDS). The MDS was conceived originally to assist nursing facilities in developing appropriate patient care plans for nursing facility residents[14]. The Department of Public Health already uses the MDS data for target quality audits in nursing facilities. Since electronic submissions are to be required for all Medicare certified facilities in the country, a nationwide database of MDS data will be available. Such a database will allow nursing facility administrators, government regulators, and researchers to develop benchmarks and standards that will provide an opportunity to improve the quality of patient care.

5. Summary

Although the exact financial impact of the Balanced Budget Act of 1997 on Massachusetts nursing facilities remains unclear, there are a number anticipated issues that should be monitored closely. Chief among these issues are:

- The type of Medicare patients being admitted to nursing facilities should be monitored to ensure that certain type of patients, such as patients with cognitive and behavioral problems, are still receiving adequate access and quality of care. Whether changes in service patterns occurs is contingent on the incentives provided by the prospective payment system.
- Nursing facility administrators may decide to eliminate or reduce some ancillary services to Medicare patients, such as laboratory services or clinical social work services.
- Some nursing facilities will have a difficult transition to consolidated billing. This may result in payment delays for ancillary providers and additional administrative costs for nursing facilities.
- Hospital based transitional care units will be most vulnerable to Medicare payment reductions. It is possible that a number of these facilities will close or convert to other uses.
- Smaller, not-for-profit, nursing facilities are also more vulnerable to the changes implemented under the BBA.
- Medicaid utilization in nursing facilities may increase as a result of the BBA-mandated reductions in home health care.
- Medicare utilization in nursing facilities will likely remain stable, or perhaps decline.
- The electronic submission of the Minimum Data Set (MDS) will be an excellent resource for nursing facility administrators, state officials, and researchers to assess and monitor the quality of patient care nationwide.

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[1] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy, Volume I*, March 2, 1998 (Washington, DC: 1998), p. 95.
[2] Congressional Budget Office estimate, July, 1997.
[3] Estimate based on nursing homes cost report data reported to DHCFP. Excludes hospital-based transitional care units, rest homes, specialized homes (i.e. pediatric facilities), and privately funded facilities that do not file cost reports with the Division.
[4] Estimate based on data reported to the Division of Health Care Finance and Policy (DHCFP).
[5] Estimate based on nursing homes cost report data reported to DHCFP. Excludes hospital-based transitional care units, rest homes, specialized homes (i.e. pediatric facilities), and privately funded facilities that do not file cost reports with the Division.
[6] TCUs are also commonly referred to as "sub-acute units" or "hospital-based SNFs".
[7] Count based on data reported to the Department of Public Health.
[8] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy, Volume I,* March 2, 1998 (Washington, DC: 1998), p.8.
[9] Ibid., p.95
[10] 62 *Federal Register* 67207-67208 (December 23, 1997)
[11] Data for hospital-based skilled nursing unit utilization was derived from the DHCFP-403, Hospital Statement for Reimbursement.
[12] Department of Health and Human Services Office of the Inspector General, *Medicare Hospital Discharge Planning*, December, 1997 (New York: 1997)

[13] Cohen, M.A., and Tumlinson, A., "Understanding the state variation in Medicare home health care: The impact of Medicaid program characteristics, state policy, and provider attributes," *Medical Care* 35(6): 618-633, June, 1997.

[14] Clauser, S.B., and Fries, B.E., "Nursing home resident assessment and casemix classification: Cross-national perspectives", *Health Care Financing Review*, 13(4), Summer, 1992.

Section D: Home Health Services

1. Status of Industry in Massachusetts

Home health benefits were included as part of the original Medicare program to offer beneficiaries with acute conditions a less intensive and less expensive alternative to skilled nursing facility or hospital inpatient care. Since the inception of the Medicare program in 1965, the home health benefit has been modified at various times, partly to increase access for beneficiaries. In addition, in 1983 most acute care hospitals began reimbursement under a prospective payment system which provided an incentive for hospitals to discharge patients early. More recently, there has been an effort to reduce nursing facility admissions. The result of these changes was a proliferation of home health agencies, and an almost tenfold increase in Medicare home health expenditures from 1987 to 1995[1]. Currently, one hundred and ninety-nine agencies are certified to provide home health services in Massachusetts[2].

Agencies that wish to provide home health services undergo a survey to determine whether or not they meet the conditions of participation established by the Health Care Financing Administration (HCFA). Participating agencies are recertified through the state every nine to thirty-six months, depending on how well they did in previous surveys. Certified agencies can provide any or all of the following six services: skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social work, to Medicare beneficiaries. In Massachusetts, approximately eighty percent of all home health visits are provided to Medicare beneficiaries, Medicaid beneficiaries make up most of the balance.

Currently, the Medicare home health benefit covers home health services under Parts A and B. Most of the home health services are covered under Part A , where there is no deductible or coinsurance required. Medicare and Medicaid beneficiaries who qualify for home health services must be home bound, in need of skilled care, and under the care of a physician who has prescribed part-time or intermittent services. These services have few limitations in duration and must meet certain clinical criteria. These services do not require a prior hospitalization. Once treatment to a beneficiary has begun, the agency cannot stop or reduce services to that beneficiary.

2. Current Reimbursement Strategies

The current Medicare home health service reimbursement system is based on allowable costs. The Medicare home health benefit is administered through regional fiscal intermediaries, each of which serves a defined geographic region of the country. Fiscal intermediaries review claims to limit inappropriate use of services and determine reasonable costs; and they administer payments to the home health agencies, and act as the communication link between the HCFA and the agencies. Eligible agencies were reimbursed for their costs per visit up to a limit that was based on 112% of the mean national per visit cost of freestanding home health agencies until September 30, 1997. This cost reimbursement system provided no incentive for providing services efficiently, and there have been large increases in spending for home health services.

3. Changes as a Result of the Balanced Budget Act

The Balanced Budget Act of 1997 has four main changes for the provision of home health care services. It provides an Interim Payment System for the period October 1, 1997 to September 30, 1999; requires that a Prospective Payment System be implemented on October 1, 1999; shifts some of the existing benefit to Medicare Part B; and requires every home health agency to secure surety bonds in order to participate in the Medicare and Medicaid programs. Other smaller changes affecting home health agencies were also mandated by the BBA. Each of these changes will be discussed below.

a. The Interim Payment System

The BBA calls for cost limits to be returned to 1994 reported base year costs for the period October 1, 1997 through September 30, 1999. During this period, home health agencies will be paid the lowest of 1) 100% of agency's costs; 2) a per visit cap; or 3) a per-beneficiary cap.

The per visit cap will be calculated as 105% of the national median cost per visit, adjusted for wage area. The per-beneficiary cap will be calculated differently for "old" agencies than for "new" agencies.

Calculation of per beneficiary cap for "old" agencies

The base year for this method of payment is the fiscal year ending between October 1, 1993 and September 30, 1994. Using cost reports filed by the agencies for this period, adjusted for inflation, an agency-specific cost per patient is calculated and 98% of such cost is used. In addition, 98% of the regional cost per patient is calculated. Using these two figures, a per beneficiary cap is calculated for each agency, in which 75% of the final payment derives from the agency specific cost per patient and 25% derives from the regional cost per patient.

Calculation of per beneficiary cap for "new" agencies

New agencies are defined as those that were created, merged or changed ownership after October 1, 1993. These agencies will receive a per beneficiary cap based solely on national cost experience, adjusted for inflation.

b. Prospective Payment System

Before the BBA was passed, HCFA had planned to replace the reimbursement system for home health care services with a Prospective Payment System. Currently, HCFA is implementing the Per-Episode Home Health Prospective Payment Demonstration to test the extent to which prospective per-episode rate setting increases efficiency in the provision of Medicare home health care. The ultimate goal of the prospective payment system is to reduce public expenditures, while maintaining access to care and ensure quality of care. While the current reimbursement system provides no reward for efficient delivery of care, the per-episode PPS will encourage home health agencies to reduce the number of visits per episode and produce each visit at a lower cost, to generate profits.

Ninety-one agencies from California, Florida, Illinois, Massachusetts and Texas are participating in the PPS demonstration. Eleven of these are from Massachusetts. Agencies in the demonstration receive a lump-sum payment for 120 days of a HCFA home health episode. For this amount, they provide all the home health care needed during the 120 day episode, bearing all the financial risk for care during an episode. Outliers (visits beyond the 120 days) are reimbursed according to a fixed payment that is also set prospectively. Agencies that provide care for less than the fixed rates, generate profits while those that exceed the rate, incur loss. An episode is defined by a gap of at least 45 days from the last receipt of Medicare home health services. Thus, an agency can only receive a new per episode payment for a given Medicare beneficiary after this gap.

In the PPS demonstration, per-episode rates are based on an agency's costs for the first 120 days of care in the fiscal year preceding its participation in the demonstration (base year). The base year rates are adjusted for inflation and changes in the agency's case-mix in each demonstration year, relative to the base year. Payment for outliers is also based on the agency's base year per visit costs, adjusted for inflation. PPS payment rates are expected to reduce home health care expenditures.

The Balanced Budget Act of 1997 requires a Prospective Payment System to become effective October 1, 1999. The Secretary of Health and Human Services will have broad discretion in establishing this PPS, including: the unit of payment; the payment period; the number, type and duration of visits provided within that unit; the type of adjustments; and the recognition of regional differences. The final PPS system has not been announced; it is expected that some changes to the current demonstration PPS will be made.

c. Partial shift of benefit to Medicare Part B

The BBA mandates that over a six year period, post-hospitalization home health services provided after the first one hundred visits (100) be phased in, to eventually be covered completely by Medicare Part B. A post-hospitalization service follows a beneficiary's stay in a hospital or skilled nursing facility of three or more days. To maintain continuous operation of the system, the Part A fiscal intermediaries will continue to administer this benefit. In addition, a sequential billing requirement is required of agencies in order for visits to be counted to achieve this shift.

d. Surety Bond, Referral, and Disclosure Requirements

The BBA requires home health agencies to obtain separate surety bonds in order to participate in the Medicare and Medicaid programs. Each surety bond will be the greater of $50,000 or fifteen percent (15%) of the annual amount paid to the agency by the Medicare or Medicaid program, as reflected in the agency's most recent cost report to the Secretary (for Medicare), or reflected on their 1099 form (for Medicaid). In addition, the BBA prohibits a hospital, while discharge planning, to limit its referrals to affiliated home health agencies; and it requires a hospital to maintain and disclose information related to referrals made to entities in which the hospital has a financial interest

e. Other Changes

In addition to the changes described above, the BBA requires other smaller changes that will affect home health agencies. For example, effective October 1, 1997, the BBA requires agencies to submit claims based on the location where a service was actually provided, rather than the location of the agency. This provision eliminates the ability of agencies located in rural areas, whose home offices are in urban areas, from taking advantage of the higher wage rates in urban areas when services are delivered in rural areas.

The BBA also tightens the part-time or intermittent care standard for coverage and clarifies that venipuncture or the drawing of blood does not qualify as a basis for home health care coverage. Beginning February 1998, home health agencies can no longer provide home health aide visits for patients receiving venipuncture as their only skilled nursing service. This provision of the BBA may affect rural agencies that may have a number of patients who receive this service only, but are too sick to travel to a doctor's office .

The BBA requires a home health agency to submit claims for all services furnished to an individual under a plan of care of that agency . Thus, all payments will be made to the agency without regard to whether the service was furnished through a subcontract. This calls for a revision of all contracts by home health providers, and subsequently, an added administrative cost which small agencies might not have the ability to absorb.

4. Impact of the Balanced Budget Act

a. Impact on Providers

The interim payment system is of great concern to providers in Massachusetts. The primary concern with the interim payment system is the per beneficiary cap. This is a single per beneficiary reimbursement, regardless of patient acuity. In Massachusetts, many providers have significantly increased their case mix since 1993/94 which is the cost reporting period used to calculate the beneficiary caps. There has been an effort in Massachusetts to decrease nursing home utilization by increasing Medicare home health care for the Medicaid eligible population. Shifts in patient acuity are not captured in this calculation and may hurt a number of providers. The agency-specific per-beneficiary cap aims to reduce federal spending by tying agency costs to regional averages, which should begin to move agencies within the same region to more similar utilization patterns.

Another problem with the interim system in Massachusetts, is the definition of a "new agency." Many agencies that consider themselves "old", will end up as "new" because they merged or changed ownership after FY 1993. The impact on such providers will even be greater. Finally, the timing of this reimbursement change has been a major problem for providers in Massachusetts. Agencies have had their reimbursement dramatically cut with very little notice. In addition, agencies have yet to receive their caps effective October 1, 1997, which means they have been providing

services for seven months without knowing their fiscal situation.

HCFA estimates that 85% of old agencies and 91% of new agencies in New England will be above the per beneficiary cap. Preliminary estimates calculated for this report show that the average HCFA reimbursement per patient in 1996 was 17% greater than the average per beneficiary cap that will be used for the interim payment period (10/1/97 - 9/30/99). This amounts to an estimated loss in revenue of almost $111 million dollars per year to home health agencies in Massachusetts during the interim payment period. The impact may be even greater if the volume of patients has increased from 1996 to present.

The BBA calls for a fifteen percent further reduction in the reimbursement rate during the implementation of the PPS. In essence, home health agencies will receive 85% of what they received in the fiscal year preceding the implementation of PPS, i.e., the year ending September 30, 1999.

During the PPS demonstration, it was found that while most prospectively paid agencies decreased the number of visits per client, this decrease was not uniform. While the proprietary and large agencies did bring their visit numbers down with ease, the small and non-profits did not.[3] Thus, the impact of the PPS may be felt by the small and non-profit organizations more than the large ones. Those agencies that reduced the number of visits increased their administrative efforts such as increasing coordination, supervising utilization more carefully, and replacing visits with telephone calls.[4]

The surety bond provisions are meant to combat fraud and abuse within the home health industry. However, they will affect the financial planning and administration of home health care providers, and may compel a significant number of less successful agencies to close. The small agencies, which are more susceptible, should be monitored, since closure of agencies could pose an access problem for beneficiaries.

b. Impact on Medicaid

In Massachusetts, we expect to see some cost shifting from Medicare to Medicaid. Of particular concern are the chronically ill Medicare beneficiaries who have already started to complain about their providers' plans to limit the number of visits. Patients whose services are dropped or shortened by home health agencies might end up in long term care facilities and will soon be covered by Medicaid. Similar access issues may be encountered by dually eligible patients. Patients covered by both Medicaid and Medicare tend to require relatively more service provision, and are administratively more difficult for agencies to serve. Thus, this population may already be experiencing difficulties accessing home health care, a situation that may be exacerbated by the BBA changes.

c. Impact on Consumers

The home health changes mandated by the BBA may negatively impact access to home health care for Medicare beneficiaries. Prospective payment carries with it

financial incentives to under-treat. The BBA requirement that home health prospective payments be reduced by 15% presents a sharp incentive for agencies to provide very efficient home health care. In addition, the shift of home health services from Medicare A to B will likely include implementation of co-payments, among other methods for reducing the growth in federal expenditures for home health services. Individual consumers may find themselves in the situation of paying steep co-payment expenses for home health care. Individuals with restricted access to home health care and facing additional out of pocket expenditures for these services may find access to home health care to be prohibitive and may choose to be admitted to long term care facilities.

5. Summary

The Balanced Budget Act of 1997 has four main provisions for home health care. It provides an Interim Payment System for the period October 1, 1997 to September 30, 1999; requires that a Prospective Payment System be implemented October 1, 1999; transitions some of the home health care benefit to Medicare Part B, and requires every home health agency to secure surety bonds in order to participate in the Medicare and Medicaid programs.

These provisions will increase liability risks for agencies under the new system of restricted payment. Agencies are also faced with additional administrative costs. The small, non-profit, and rural agencies are more likely to feel the impact of the BBA than others. In addition, agencies who have changed their case-mix over the past several years, or who have changed ownership status, will be at increased risk. Finally, agencies may choose not to care for certain high cost and high acuity patients. This may result in a large number of chronically-ill patients being admitted to long term care facilities at significantly greater cost to both the Medicare and Medicaid programs.

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[1] Kenney Genevieve et al, "State Spending for Medicare and Medicaid Home Care Programs," *Health Affairs*, 1998, 17(1): 201-212.

[2] Part A Fiscal Intermediary, Associated Hospital Service of Maine.

[3] Mathematica Policy Research, Inc. "Transition Within a Turbulent System: An Analysis of the Initial Implementation of the Per-Episode Home Health Prospective Payment Demonstration," 1997.

[4] Mathematica Policy Research, Inc. "Transition Within a Turbulent System: An Analysis of the Initial Implementation of the Per-Episode Home Health Prospective Payment Demonstration," 1997.

Section E: Managed Care

1. Status of Industry in Massachusetts

The majority of Massachusetts' seniors receive Medicare benefits from health care providers who are reimbursed on a fee-for-service basis. Traditional Massachusetts Medicare providers agree to accept assignment from Medicare, meaning that they accept the Medicare fee-for-service payment as full reimbursement and do not balance bill Medicare beneficiaries. Beneficiaries who participate in the traditional fee-for-service Medicare program may also subscribe to Medicare supplemental insurance, commonly known as Medigap policies. These supplemental plans pay for many costs not covered by the traditional Medicare program, including deductibles and co-insurance. There is a limited range of supplemental policies available to beneficiaries, and some types are more comprehensive than others. About 31% of Massachusetts Medicare beneficiaries purchase Medi-Gap coverage[1]. Some additional portion is provided Medi-Gap coverage by previous employers.

Currently, about 17% of Massachusetts Medicare beneficiaries are enrolled in Medicare managed care plans[2]. The Medicare program permits only managed care plans that are state licensed HMOs to participate in its managed care option, in Massachusetts. HMO refers to a legal corporation that combines health care financing and delivery in a single organization for enrollees within a geographical area and through a specified panel of providers. HMOs generally accept a fixed, prepaid premium amount from payers such as Medicare or employers regardless of the actual services used or costs incurred. Point of Service plans (POS) is a type of managed care plan that allows patients to choose how to receive services at the point when the services are needed. They may use "out of network providers" for an additional fee. Under state law, POS plans have not been allowed in Massachusetts for Medicare beneficiaries. In Massachusetts, HMOs are required to offer a plan with unlimited prescription drug benefits with limited co-payments. HMOs may also sell a product without prescription drug coverage.

2. Current Reimbursement Strategies

Medicare's traditional indemnity plan reimburses providers for each unit of service or procedure performed. Medicare determines the fee-for-service payment amount using cost-based methodologies. These strategies have become increasingly sophisticated over the years, to include hospital reimbursement based on diagnosis related groups (DRGs), and physician reimbursement based on Resource Based Relative Value Scales (RBRVS).

Medicare's managed care program reimburses managed care plans using a prepaid capitation rate, called the Average Annual Per Capita Cost or AAPCC. The AAPCC is a payment made to a managed care plan for each Medicare beneficiary enrolled in the plan. These payments vary according to a limited number of variables including geography, age and gender.

3. Changes as a Result of the Balanced Budget Act

As discussed elsewhere in this report, a number of changes will be made to Medicare's traditional indemnity plan as a result of the BBA. In fact, the predominant source of the Medicare savings in the BBA will be reductions in provider payments and growth rates in the traditional fee-for-service program. For example, the BBA establishes a single conversion factor for all physician services (including surgery and non-surgical procedures) which is updated annually by the Medicare Economic Index (MEI). However, there are also financial incentives in the BBA to re-direct beneficiaries to more cost efficient providers in the indemnity plan. For example, nurse practitioners and physician assistants' payments increase under the BBA which may result in an increase in such practitioners. There are also expanded preventive health care benefits for mammography, pap smears, diabetes, prostate and colorectal cancer screening, bone density measurement and vaccines.

There are three important changes in the BBA that will effect Medicare's managed care program. First, there will be an increase in the number of options available to Medicare beneficiaries as a result of the BBA. Second, Medicare has been directed to introduce a new capitation methodology that takes into account variation in severity of illness among enrollees, and average national costs. Third, Medicare has been directed to gather encounter data from managed care plans in order to be able to monitor plan performance more effectively. Each of these changes is discussed below.

a. New Medicare + Choice Program

The BBA introduces several new options that Medicare beneficiaries may choose instead of the traditional fee-for-service program. Together, these plans are referred to as the Medicare + Choice Program. Under the Medicare + Choice Program, beneficiaries may enroll in one of four basic programs. These include 1) Coordinated Care Plans; 2) Medical Savings Accounts (MSA's); 3) Private Fee-For-Service Plans; and 4) Religious Fraternal Benefit Society Plans. Information about these options is provided below.

Coordinated Care Plans

Coordinated Care plans include three categories of managed care plans: HMOs, PPOs, and PSOs. The HMO option is currently available in Massachusetts under Medicare's managed care program, as described above. The PSO, or Provider Sponsor Organization, option will be expanded as a result of the BBA. The PPO option discussed earlier will also become available to Massachusetts' seniors as a result of the BBA.

A PSO is defined as a public or private entity established by health care providers, which provides a substantial portion of health care items and services directly through affiliated providers who share, directly or indirectly, substantial financial risk. The PSO Plans are closed networks operated by a health care provider, such as a hospital, or by an affiliated group of health care providers, such as the rehabilitation unit of a hospital. PSOs provide a substantial portion of health care required under the Medicare contract through that provider or group. It is envisioned that PSOs will be one way to bring Medicare managed care to rural or under-served communities, since these

PSOs will be reimbursed at a higher rate than other providers.

In 1996 HCFA launched demonstration programs for 10 PSO plans. Published reports with results have not been issued by HCFA because demonstration projects have not been operating long enough to have measurable results. However, the experience of two participating hospital systems, Florida Hospital Health Care and Mount Carmel Health System, Columbus, Ohio, suggests that plans will need to focus on medical management efforts, since 5% of plan members account for 60% of costs. Moreover, the amount of effort, cost and time both organizations took to implement this pilot program was greater than expected.[3]

Medical Savings Accounts

Beginning in January, 1999, up to 390,000 beneficiaries will have the choice (on a demonstration basis ending January 1, 2003) of enrolling in a Medical Savings Account (MSA) option. Under this option, beneficiaries would obtain high deductible health insurance policies that pay for at least all Medicare-covered items and services after an enrollee meets the annual deductible of up to $6,000. The difference between the premiums for such high deductible policies and the applicable Medicare + Choice premium amount would be placed into an account for the beneficiary to use in meeting his or her deductible expenses. Under the MSA Plan there are few restrictions on insurance coverage, no balance billing protections (Medicare protection that prohibits physicians from charging the beneficiary over the Medicare Fee Schedule), and no requirements that MSAs have stop loss arrangements on out-of-pocket expenses.

Seniors choosing a health plan with a $3,000 deductible could receive an MSA deposit as high as $2,100. The beneficiary pays the first $2,100 out of the MSA and the next $900 out-of- pocket. The plan would pay all catastrophic expenses above $3,000. Catastrophic definitions vary from plan to plan. The beneficiary can assume that all outpatient medical services above $3,000 would continue to be out-of-pocket expenses. If an MSA account accumulates more than 60% of the annual deductible level, the amount above that level can be withdrawn (taxable income) and used for consumer purchase.

This plan is expected to draw members from healthy and affluent backgrounds who will benefit from it monetarily. Individuals in poor health and limited financial means could face financial burdens and risk needed health care if they choose this type of program.

Private Fee-For-Service Plans

Private fee-for-service plans reimburse providers on a fee-for-service basis, and are authorized to charge enrolled beneficiaries up to 115% of the plan's payment schedule (which may be different from the Medicare provider fee schedule). Private fee-for-service plans are reimbursed for each unit of service or service performed. This plan is cost based, but unlike traditional fee-for-service plans, the plan will determine the fees. Physicians may bill up to 115% of the rate determined by the private fee-for-service plan. This may result in greater costs to beneficiaries who choose this option. Providers who now reluctantly take Medicare recipients may opt out of the traditional

plan if they can achieve better payment under the private fee-for-service plans. These plans are more likely to discourage low-income beneficiaries in poor health from selecting the plan.

Private plans will be able to pay providers higher fees and offer more benefits. Thus, private fee-for-service plans established in rural areas will receive higher payments than those providers who remain in the traditional program. Nationally, if providers have been reluctant to offer certain benefits because of restrictions on balance billing, private fee-for-service plans may change these incentives. Without balance billing provisions, and with enhanced rates, access to certain services may be increased under this option.

Religious Fraternal Benefit Plans

Religious fraternal benefit society plans are a new option that may restrict enrollment to members of the church, convention or group with which the society is affiliated. Payments to such plans may be adjusted, as appropriate to take into account the actuarial characteristics and experience of plan enrollees. Details about the operation of this Medicare + Choice option are still being developed.

b. Changes in Capitation Rates

Under the BBA, Medicare has been directed to begin paying managed care plans using different capitation rates than those based on the traditional AAPCC. The new methodology will take into account some adjustment for diagnosis and the costs associated with different diagnoses. Under this methodology, individuals with related diagnoses are clustered into groups for reimbursement purposes. This new methodology will be implemented over the coming year.

In addition, the BBA transitions AAPCC rates, which have been based solely on local fee-for-service expenditures, to a 50/50 blend of county and national average costs over a five year period. For 1998, the rates are calculated on a 90% local, 10% national blend. There is a payment floor established each year to protect providers from drastic cuts to their reimbursement in any one year.

HCFA also revised the way it will pay for GME. It will be carved out of the capitation rates to plans and paid directly to hospitals for managed care enrollees. This will benefit teaching hospitals in Massachusetts.

c. Encounter Data

The BBA has also directed HCFA to begin to gather encounter data from participating Medicare managed care plans. Traditionally, many payers, including Medicare and Medicaid, have reimbursed managed care plans using a flat capitation rate. As a result, the payers have not maintained a record of the services actually provided to beneficiaries, as this information has been maintained by the plans. In order to monitor plan performance, however, HCFA must have access to information which records services provided to individual beneficiaries. These data are typically

maintained within the plan in the form of encounter data. There are likely to be operational issues in gathering encounter data from the plans, including lack of consistency among plan information systems, difficulty in transmitting the data to HCFA, and questions about how the data will be used. This activity is likely to be resource intensive for the plans, but will result in an improved ability by HCFA to monitor quality of care for Medicare managed care enrollees.

4. Impact of the Balanced Budget Act

a. Impact on Providers

It is too early to determine exactly what the impact of the managed care changes introduced by the BBA will be on Massachusetts providers. Providers have not been given information on payment rates for many of the options. However, because most counties in Massachusetts have much higher FFS costs than the national average, AAPCC rates in most counties are expected to grow very little over the next five years. While FFS costs are expected to grow by about 18% in real (inflation adjusted) terms between 1997 and 2003, AAPCC rates in Massachusetts are expected to grow by only 3% during this period.[4] This will certainly have an impact on plans, the extra services they are able to provide to enrollees at no cost, and to the premiums, co-pays and deductibles.

Individual providers in Massachusetts are becoming more accustomed to providing health care services under managed care arrangements, and so may not have difficulty adjusting to serving additional Medicare managed care enrollees. The reimbursement change towards a case-mix adjustment should more accurately reflect the resources required to serve individual enrollees who have a range of health care conditions. As a result, plans should not face undue financial risk by enrolling individuals with relatively more resource intensive conditions.

However, some providers may be negatively affected by an increase in Medicare managed care enrollment in two ways. First, if a provider's traditional patient base enrolls in managed care plans and these plans redirect the enrollees to different providers, the providers may lose their patient base and with it, their revenue. It will be incumbent upon individual providers to become affiliated with as many managed care plans as possible in order to retain their patient base, which they probably have already done in order to retain their non-Medicare managed care patients. Second, managed care plans that contract with individual providers may reduce the payment rates compared to what the providers would have received under the traditional Medicare indemnity plan. In order to retain their revenue base, providers may need to make up in volume what they lose in reimbursement if these visits are reimbursed by the plan at a lower level.

These provider impacts may be disproportionately experienced by providers that serve a large Medicare beneficiary population. For example, for hospitals for whom Medicare is the largest payer, the effects of increased managed care enrollment will be larger than for other providers. The effects may also be greater for traditional safety net providers who are being squeezed simultaneously by reimbursement changes by Medicaid.

In addition to these reimbursement related changes, managed care plans will be impacted by the requirement to submit encounter data to HCFA. Although these data will be invaluable to HCFA in monitoring plan performance, plans will be required to extend their resources in order to submit the necessary data to HCFA in the required format.

b. Impact on Medicaid

An increased emphasis on managed care in Medicare may impact the Medicaid program for individuals who are eligible for both programs. Massachusetts' Medicaid program requires individuals in most eligibility categories to enroll in managed care plans. One group that has presented operational challenges to Medicaid and to managed care plans includes those who are eligible for both programs, since Medicare does not require enrollment in managed care arrangements. With increased efforts to enroll Medicare beneficiaries in managed care plans, Massachusetts Medicaid may benefit from the willingness of HCFA to overcome these operational challenges. Currently, Massachusetts Medicaid is working closely with HCFA to develop managed Senior Care Organizations, or SCOs. The SCOs would enroll individuals who are eligible for both Medicaid and Medicare, and would bring services reimbursed by both payers, as well as other services, under a single capitated arrangement. One issue that will affect the enrollment in the SCOs is that Medicare managed care enrollment has been voluntary but, as stated above, will be encouraged.

c. Impact on Consumers

The impact of the BBA changes on consumers in Massachusetts is unclear. Certainly, seniors will have more choice regarding how their health care is delivered in the future. However, enrollment in these options will continue to be voluntary, and it is unclear how many individuals will choose to enroll in one of the new options. One factor that may encourage individuals to enroll is the rising cost of Medicare supplemental policies. For individuals who currently purchase Medigap policies, the new options may be an attractive lower cost alternative.

The Medicare + Choice Program has included several consumer, and fraud and abuse protections in the design. The plans are:

- required to make medically necessary care available 7 days a week, 24 hours a day.
- prohibited from restricting providers' advice to beneficiaries about medical care or treatment (the "Gag Rule")
- required to have grievance and appeal mechanisms in place to protect beneficiary rights.
- required to provide coverage for care that a "prudent lay-person" would consider an emergency.
- required to submit to binding advisory opinions for physician self-referral
- required to include new details about Medicare fraud and fraud prevention with beneficiary's explanation of benefits
- required to provide beneficiaries who directly contract with physicians (Kyle

Amendment) written notice of charges prior to service and beneficiaries have the right to have the service performed by a Medicare provider.
- required to disclose Owner Interest in which the provider direct or indirectly has 5% or more ownership interest in a facility to which he/she refers

Also,

- beneficiaries retain the ability to enroll or disenroll continuously from a Medicare + Choice plan.
- providers convicted of three health care related crimes are permanently excluded from the system. Civil monetary penalties may be imposed on persons who contract with excluded individuals.
- a new toll-free number for beneficiaries to report fraud and billing irregularities directly to the Inspector General of Health and Human Services is established

These protections, as well as the overall design of the Medicare + Choice Program are intended to make the program attractive to Medicare beneficiaries so that they will enroll in one of the expanded options.

Even with the consumer protections HCFA has developed for Medicare + Choice, there are potential risks for beneficiaries who enroll in these programs. These risks include under-provision of services and reduced access to needed care. Moreover, HCFA has taken the position that state mandated benefits and state review of coverage determination are superseded by federal law.

5. Summary

There are three important changes in the BBA that will effect Medicare's managed care program. First, there will be an increase in the number of options available to Medicare beneficiaries as a result of the BBA. Second, Medicare has been directed to introduce a new capitation methodology that takes into account variation in severity of illness among enrollees, and national average costs. Third, Medicare has been directed to gather encounter data from managed care plans in order to be able to monitor plan performance more effectively.

The BBA introduces several new plans that Medicare beneficiaries may choose from instead of the traditional program. Together, these plans are referred to as the Medicare + Choice Program. Under the Medicare + Choice Program, beneficiaries may enroll in one of the four basic types of plans. These include 1) Coordinated Care Plans; 2) Medical Savings Accounts (MSAs); 3) Private Fee-For-Service Plans; and 4) Religious Fraternal Benefit Society Plans. It is unclear how desirable these different plans will be, or their precise impact on providers, consumers and Medicaid.

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[2] Short, P.F., and Vistnes, J.P. "Multiple Sources of Medicare Supplementary Insurance." *Inquiry*. Spring; 29 (1): 33-43. 1992.

[3] Rural Policy Research Institute, Rural Policy Brief, March, 1998. and *The Economic and Budget Outlook: Fiscal Years 1997-2008*, Appendix F: Medicare Projections. Congressional Budget Office.

[4] Cunningham, Robert. Editor, "Struggling Choices Demo Full Warning Signs for Aspiring Medicare PSOs," *Medicine & Health Perspectives*, March 30, 1998. p. 1.

Section F: Repeal of the Boren Amendment

As part of the Balanced Budget Act of 1997, Congress repealed the so-called Boren Amendment. This amendment, enacted in 1981, required states to pay hospitals, nursing homes and intermediate care facilities for the mentally retarded, at Medicaid rates that were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." A number of state reimbursement systems were challenged under this provision, and some courts found that state systems did not meet the Boren standard.

The Balanced Budget Act repealed the Boren Amendment and established a public notice process for proposed rates and rate methodologies. States must now publish in advance a description and justification of any proposed change in rate methodology, as well as the proposed rates. These are subject to public review and comment before adoption.

In the national arena, some providers have expressed fear that the repeal of the Boren Amendment will give states free rein to markedly reduce Medicaid rates. Significant reductions are unlikely, however, as states are still required to assess the impact of proposed rates on access and quality. Establishing unreasonably low rates would adversely impact access and quality in the long run. In addition, the procedural safeguards of the new law insure that providers will be notified of both the reasons for rate methodology changes and the projected impact of those changes, and that they will be given an opportunity to comment on the proposed changes.

For these reasons, the repeal of the Boren Amendment is likely to have little effect on the Medicaid rates paid by the states, including the Commonwealth of Massachusetts. In addition, current Massachusetts state law imposes a standard similar to Boren in determining certain Medicaid rates of payment. M.G.L. c.118G requires the Division of Health Care Finance and Policy to "impose such methods and standards as are necessary to ensure reimbursement for those costs which must be incurred by efficiently and economically operated facilities and providers." The Division establishes Medicaid rates for acute hospitals which provide a disproportionate share of services to low income patients, nursing homes, and ambulatory care providers.

Chapter 3: Future Issues

The Medicare provisions of the BBA have both short-term and long-term implications for providers, consumers and Medicaid. In the short-term, acute care hospital profit margins will be squeezed. Total profit margins across all acute care hospitals will hover around 2% over the next five budget years, compared to an otherwise expected steady climb to roughly ten percent in 2002. Average total profit margins weighted by each facility's share of total costs, however, will remain at or below 1% over the next five years, compared with a projected steady increase to around 9% by 2002 without the BBA. Over the next five years, acute care hospitals will have to adjust to profit margins a few percentage points below historic levels. The financial stability of small community hospitals, already operating at seriously low levels of profit, will be most threatened by the short-term reduction in payment.

Reductions in the rate of growth of hospital payment will be compounded by other provisions of the BBA whose impacts are not included in the quantitative analysis provided in this report. As stated in Section A, outlier payments will no longer be based on IME and DSH adjustments, leading to lower levels of reimbursement for teaching and disproportionate share hospitals. Offsetting this reduction, however, is the elimination of the policy of reducing estimated costs by IME and DSH adjustments when determining whether a particular discharge exceeds the outlier cost threshold. Hospital profit margins will be further affected by the reduction in payments for some patients transferred to sub-acute care facilities, as well as the restrictions on consolidated billing. It is also worth pointing out that many hospitals, particularly those that operate facility-based transitional care units or other units exempted from prospective payment, will be affected by reimbursement changes pertaining to more than one sector of the health care industry. Finally, it is important to keep in mind that, if more and more hospitals continue moving into the sub-acute care market, changes in Medicare payment policy in one sector will have implications for hospitals' various other lines of business.

In the long-run, the BBA will stand as a turning point in Medicare's reimbursement of sub-acute care facilities, as well as in its relationship with managed care. The federal legislation represents a dramatic expansion in the continuum of providers covered by the prospective payment system (traditionally limited to acute care hospitals only), including chronic, rehabilitation and psychiatric facilities and units, skilled nursing facilities and units, home health agencies, and hospital outpatient departments. Since prospective payment systems represent a transfer in risk from the payer (Medicare) to the provider, providers with below average costs or those that treat a relatively healthy patient population will benefit, while those with above average costs or treat a relatively sicker patient population will be made worse off by the change. To assess the full impact of the expansion, policy makers and health care advocates will want to pay close attention to the details of the proposed payment systems as they emerge over the next few years ahead. It will also be important to monitor the impact of the expanded PPS over time on the quality of and access to non-acute care services, as well as the potential cost-shifting to Medicaid.

Finally, the BBA represents the federal government's full embrace of managed care as a viable model for meeting the health care needs of the elderly and permanently

disabled population. Most likely, increasing numbers of Medicare beneficiaries will begin taking advantage of the various managed care options now available under the new regulations as incentives to enroll in managed care mount (e.g., relative increases in premiums, co-payments or deductibles under indemnity plans or increases in the cost of supplemental insurance). While a shift from fee-for-service plans to managed care plans will undoubtedly save money, it also represents a shift from a benefit entitlement program in which the elderly and permanently disabled are entitled to a fixed health care benefit to a contribution program in which beneficiaries are guaranteed a fixed amount of funds to purchase health insurance through a variety of delivery models. As the new Medicare + Choice program unfolds, it will be important for states to carefully monitor the continued availability of current health care benefits.

Appendices

Appendix A: A Note on Medicare Benefits

Who is eligible for Medicare?

An individual is eligible for the federal Medicare program if:

- the person or the person's spouse worked at least 10 years in Medicare-covered employment,
- the person is 65 years or older, and
- the person is a citizen or permanent resident of the United States.

For a person under 65 to qualify for Medicare, the person must:

- be receiving social security or railroad retirement board disability benefits for 24 months, and
- be a kidney dialysis or kidney transplant patient.

In Massachusetts, there were approximately 973,000 individuals eligible for Medicare in 1996[1].

Medicare benefits

The Medicare program is divided into two parts: Part A and Part B. Part A covers inpatient hospital, skilled nursing facility services, home health, and hospice care. Beneficiaries pay no premiums for Part A. Part B pays for doctors, outpatient hospital care, durable medical equipment, and other medical services not covered under Part A. Patients must pay a premium for Part B coverage. Both Part A and Part B require some co-insurance and deductible payments. The following tables highlight the Medicare benefits. Please note that not all covered services are included in the tables. We have chosen to highlight only those services most relevant to this report.

[1] Estimate from the Commonwealth of Massachusetts Division of Insurance, as of December 31, 1996.

Part A hospital coverage (1997):

To qualify for Part A hospital coverage, four requirements must be met:

- A doctor prescribes inpatient hospital care for an illness or injury,
- the illness or injury requires care that can be provided only in a hospital,
- the hospital participates in the Medicare program, and
- the hospital's utilization review committee or a Peer Review Organization did not disapprove of the stay.

The benefits are as follows:

Services	Benefit	Medicare pays	Patient pays
Hospitalization Semiprivate room and board, general nursing and other hospital services and supplies	First 60 days	All but $760	$760
	Day 61 to Day 90	All but $190 a day	$190 a day
	Day 91 to Day 150 (reserve days - once a lifetime)	All but $380 a day	$380 a day
	Over 150 days	Nothing	All costs

Source: *Your Medicare Handbook: 1997*, US Department of Health and Human Services, Health Care Financing Administration, Washington, DC, 1997.

Part A Skilled Nursing Facility (SNF) coverage (1997):

To qualify for Part A SNF coverage, six requirements must be met:

- The patient requires skilled nursing or rehabilitation services than can only be provided in a SNF,
- the patient was in a hospital 3 days in a row, not counting the day of discharge, before entering the SNF,
- the patient was admitted to the facility within a short period of time (usually 30 days) after leaving the hospital,
- the condition for which the patient is receiving skilled nursing care is the same condition being treated in the hospital or a condition that arose while the patient was in the hospital,
- a medical professional certifies that daily skilled nursing or rehabilitation care is necessary, and
- the SNF participates in the Medicare program.

The benefits are as follows:

Services	Benefit	Medicare pays	Patient pays
Skilled Nursing Facility Care Semi-private room and board, nursing and rehabilitation services, other services and supplies	First 20 days	100%	$0
	Next 80 days	All but $95 per day	$95 per day
	Over 100 days	Nothing	All costs

Source: *Your Medicare Handbook: 1997*, US Department of Health and Human Services, Health Care Financing Administration, Washington, DC, 1997.

Part A home health coverage (1997):

To qualify for Part A home health coverage, four requirements must be met:

- the patient requires skilled nursing care, physical therapy , or speech language pathology,
- the patient is confined to home,
- the home health agency participates in the Medicare program, and
- a doctor determines that the patient needs home health care and sets up a plan for the patient to receive care at home.

The benefits are as follows:

Services	Benefit	Medicare pays	Patient pays
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services.	Unlimited as long as patient meets Medicare requirements for home health care benefits.	100% of approved amount for services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment.

Source: *Your Medicare Handbook: 1997*, US Department of Health and Human Services, Health Care Financing Administration, Washington, DC, 1997.

Note: If a patient does not have Medicare Part A, Part B requirements and benefits for home health care are identical to those listed above.

Other Part B Covered Services (1997):

Services	Benefit	Medicare pays	Patient pays
Medical Expenses Physician services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment.	Unlimited services if medically necessary, except for the services of independent physical and occupational therapists	80% of approved amount, after $100 deductible. 50% of approved amount for most outpatient mental health services. up to $720 per year for independent physical and occupational therapy	$100 deductible (once a year). 20% of approved amount after deductible, all charges above approved amount. 50% for most outpatient mental health services. 20% of first $900 for independent physical and occupational therapy and all charges thereafter.
Outpatient Hospital Services Services for the diagnosis and treatment of an illness or injury.	Unlimited if medically necessary	Medicare payment varies to hospital based on service	20% of whatever the hospital charges (after $100 annual deductible)
Clinical Laboratory Services Blood tests, urinalysis, etc.	Unlimited if medically necessary	Generally 100% of approved amount.	Nothing

Source: *Your Medicare Handbook: 1997*, US Department of Health and Human Services, Health Care Financing Administration, Washington, DC, 1997.

Note: Other Medicare covered services include hospice benefits and coverage for blood services.

Appendix B: Methodology and Tables Used in Acute Care Hospital Analysis

The primary sources of financial data used for the financial analysis provided in the acute care hospital section were the hospital cost reports on file with the state's Division of Health Care Finance and Policy (DHCFP) and the hospital cost reports on file with Medicare. The state's hospital cost reports for the most recent three years on file (1994-1996) were used to develop cost and revenue estimates for 1997, the base year for this analysis. Medicare inpatient revenue was calculated as total Medicare net patient service revenue (which includes inpatient and outpatient payments) minus bad debt multiplied by the ratio of Medicare inpatient gross patient service revenue over Medicare total gross patient service revenue. Medicare costs were calculated as total costs including capital per case mix adjusted discharge multiplied by the Medicare case mix index. The Medicare case mix indices were based on cost weights available from the state's hospital discharge files (also maintained by DHCFP). The hospital-specific case mix adjusted discharges (CMADs) and Medicare case mix index, crucial for adjusting for the higher medical resource requirements of Medicare beneficiaries, were developed by DHCFP staff.

HCFA's 1996 cost reports were used to estimate base year revenues for each component of inpatient PPS. The reimbursement guidelines prior to and after the enactment of the new legislation were then applied to base year revenues to estimate hospital payment under the baseline and BBA scenarios, respectively. Using realistic assumptions about changes over time in patient case mix and input prices, Medicare and total profit margins were then projected for each of the five years encompassed by the federal legislation (1998-2002) for both the baseline and BBA scenarios. Outlier payments, adjustments for IME and DSH-related expenditures, and payments for capital and bad debt were calculated as a constant share of total payment. The case mix and inflation assumptions underlying the projections, as well as the payment rates for each of the five major components of PPS both before and after the BBA was enacted, are presented in Tables B1.1 and B1.2, respectively, below.

Finally, Tables B2-B5 in this appendix reproduce the financial statistics graphically illustrated in the figures presented in the acute care hospital section of this report. Table B2 provides revenue and Medicare and total profit margins for all hospitals in Massachusetts, 1997-2002. Tables B3-B5 present the same data for each of the types of hospital classifications considered in the preceding disaggregated analysis: teach versus non-teaching hospitals; disproportionate share versus non-disproportionate share hospitals; and hospitals with less than 100 beds, between 100-200 beds, and more than 200 beds. Finally, Table B6 in this appendix provides information on bed size, number and share of Medicare discharges, teaching and disproportionate share status, and operation of a transitional care unit for each of the 74 Massachusetts acute care hospitals included in Part A of this report.

Table B1.1

Adjustments Used to Predict Baseline Financial Indicators for Acute Care Hospitals

		FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
		(Annual percentage changes)					
Revenue	Case Mix Index	2.0%	1.9%	1.8%	1.7%	1.6%	1.5%
	Operating Payment Update	2.4%	2.7%	3.0%	2.8%	2.8%	2.8%
	Capital Payment Update	0.4%	0.7%	1.0%	0.8%	0.8%	0.8%
Cost		2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

Table B1.2

Adjustments Used to Predict BBA Financial Indicators for Acute Care Hospitals

		FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
		(Annual percentage changes)					
Revenue	Case Mix Index	2.0%	1.9%	1.8%	1.7%	1.6%	1.5%
	Operating Update Payment	2.4%	0.0%	1.1%	1.0%	1.7%	1.7%
	Capital Update Payment	0.4%	-17.8%	0.0%	0.0%	0.0%	0.0%
	DSH Payments	0.0%	-1.0%	-2.0%	-3.0%	-4.0%	-5.0%
	IME Payments	0.0%	-9.1%	-7.1%	-7.7%	-8.3%	0.0%
	Bad Debt Payments	0.0%	-25.0%	-15.0%	-5.0%	0.0%	0.0%
Cost		2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Market Basket		2.4%	2.7%	3.0%	2.8%	2.8%	2.8%

Source: *Division of Health Care Finance and Policy*

Table B2

ANALYSIS OF IMPACT OF BBA ON MASSACHUSETTS ACUTE CARE HOSPITALS

(HOSPITALS=74)			FY1994	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
REVENUE (Annual Percent Change)											
Medicare	Total	Baseline		4.68%	2.22%	4.23%	4.42%	4.62%	4.32%	4.23%	4.13%
		With BBA					-1.74%	1.53%	1.41%	1.84%	2.63%
PROFIT MARGINS											
Medicare	Total	Baseline	0.08%	-1.38%	2.03%	4.13%	6.34%	8.69%	10.72%	12.63%	14.41%
		With BBA					0.48%	0.02%	-0.56%	-0.72%	-0.10%
	Weighted Average	Baseline	-1.93%	-3.88%	-0.59%	1.56%	3.83%	6.24%	8.32%	10.28%	12.11%
		With BBA					-2.07%	-2.42%	-2.91%	-3.01%	-2.36%
All Payers	Total	Baseline	5.82%	2.74%	3.31%	4.37%	5.52%	6.76%	7.86%	8.92%	9.92%
		With BBA					2.54%	2.31%	2.03%	1.95%	2.26%
	Weighted Average	Baseline	4.64%	1.72%	2.09%	3.11%	4.26%	5.49%	6.59%	7.64%	8.64%
		With BBA					1.31%	1.13%	0.88%	0.83%	1.14%

Source: *Division of Health Care Finance and Policy*

Table B3

ANALYSIS OF IMPACT OF BBA ON MASSACHUSETTS ACUTE CARE HOSPITALS BY HOSPITAL TEACHING STATUS

TEACHING HOSPITALS (N=40)			FY1994	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
REVENUE (Annual Percent Change)											
Medicare	Total	Baseline		-5.58%	-2.91%	4.22%	4.42%	4.62%	4.33%	4.23%	4.13%
		With BBA					-2.15%	1.04%	0.94%	1.37%	2.50%
PROFIT MARGINS											
Medicare	Total	Baseline	2.66%	0.89%	4.75%	6.78%	8.94%	11.23%	13.21%	15.06%	16.80%
		With BBA					2.83%	1.91%	0.88%	0.26%	0.75%
	Weighted Average	Baseline	0.89%	-0.98%	2.37%	4.44%	6.65%	8.99%	11.02%	12.92%	14.70%
		With BBA					0.48%	-0.34%	-1.30%	-1.86%	-1.33%
All Payers	Total	Baseline	7.90%	4.06%	5.10%	6.09%	7.17%	8.34%	9.38%	10.38%	11.34%
		With BBA					4.18%	3.74%	3.26%	2.97%	3.20%
	Weighted Average	Baseline	6.95%	3.22%	4.06%	3.91%	4.75%	5.66%	6.46%	7.24%	7.97%
		With BBA					2.43%	2.12%	1.77%	1.57%	1.75%

NON-TEACHING HOSPITALS (N=34)			FY1994	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
REVENUE (Annual Percent Change)											
Medicare	Total	Baseline		-1.91%	-0.05%	4.26%	4.40%	4.60%	4.31%	4.21%	4.11%
		With BBA					-0.53%	2.97%	2.79%	3.20%	2.98%
PROFIT MARGINS											
Medicare	Total	Baseline	-7.80%	-8.56%	-6.83%	-4.51%	-2.11%	0.43%	2.64%	4.70%	6.64%
		With BBA					-7.17%	-6.16%	-5.34%	-4.12%	-3.12%
	Weighted Average	Baseline	-9.70%	-12.27%	-9.19%	-6.82%	-4.36%	-1.76%	0.49%	2.60%	4.58%
		With BBA					-9.49%	-8.45%	-7.61%	-6.35%	-5.32%
All Payers	Total	Baseline	-2.28%	-2.46%	-3.78%	-2.43%	-1.01%	0.53%	1.88%	3.17%	4.40%
		With BBA					-3.97%	-3.39%	-2.92%	-2.20%	-1.61%
	Weighted Average	Baseline	-3.45%	-3.81%	-5.09%	-0.90%	-0.49%	-0.16%	0.13%	0.40%	0.66%
		With BBA					-1.12%	-1.00%	-0.89%	-0.74%	-0.61%

Source: *Division of Health Care Finance and Policy*

Table B4

ANALYSIS OF IMPACT OF BBA ON MASSACHUSETTS ACUTE CARE HOSPITALS BY HOSPITAL DISPROPORTIONATE SHARE STATUS

DISPROPORTIONATE SHARE HOSPITALS (H=31)			FY1994	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
REVENUE (Annual Percent Change)											
Medicare	Total	Baseline		5.79%	5.02%	4.22%	4.42%	4.62%	4.33%	4.23%	4.13%
		With BBA					-2.21%	1.08%	0.98%	1.39%	2.46%
PROFIT MARGINS											
Medicare	Total	Baseline	0.98%	0.02%	4.86%	6.88%	9.04%	11.32%	13.30%	15.15%	16.89%
		With BBA					2.88%	2.00%	1.01%	0.41%	0.86%
	Weighted Average	Baseline	-0.91%	-2.17%	2.99%	5.05%	7.25%	9.57%	11.58%	13.47%	15.24%
		With BBA					1.03%	0.21%	-0.74%	-1.31%	-0.84%
All Payers	Total	Baseline	6.35%	3.10%	4.71%	5.68%	6.75%	7.90%	8.93%	9.91%	10.86%
		With BBA					3.77%	3.36%	2.91%	2.63%	2.84%
	Weighted Average	Baseline	5.21%	2.30%	3.66%	3.08%	3.79%	4.56%	5.25%	5.90%	6.53%
		With BBA					1.81%	1.56%	1.28%	1.11%	1.25%

NON DISPROPORTIONATE SHARE HOSPITALS (H=43)			FY1994	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
REVENUE (Annual Percent Change)											
Medicare	Total	Baseline		2.87%	-2.43%	4.25%	4.41%	4.61%	4.32%	4.22%	4.12%
		With BBA					-0.96%	2.25%	2.10%	2.56%	2.89%
PROFIT MARGINS											
Medicare	Total	Baseline	-1.38%	-3.69%	-3.03%	-0.81%	1.52%	3.98%	6.11%	8.11%	9.99%
		With BBA					-3.82%	-3.57%	-3.47%	-2.90%	-2.01%
	Weighted Average	Baseline	-3.56%	-6.63%	-6.52%	-4.22%	-1.82%	0.72%	2.93%	5.00%	6.93%
		With BBA					-7.20%	-6.77%	-6.52%	-5.81%	-4.87%
All Payers	Total	Baseline	4.73%	1.97%	0.31%	1.56%	2.89%	4.32%	5.58%	6.79%	7.94%
		With BBA					-0.13%	0.02%	0.07%	0.39%	0.88%
	Weighted Average	Baseline	3.51%	0.52%	-1.14%	-0.04%	0.47%	0.93%	1.34%	1.73%	2.11%
		With BBA					-0.49%	-0.43%	-0.40%	-0.28%	-0.12%

Source: *Division of Health Care Finance and Policy*

ANALYSIS OF IMPACT OF BBA ON MASSACHUSETTS ACUTE CARE HOSPITALS BY HOSPITAL BED SIZE

HOSPITALS WITH LESS THAN 100 BEDS (N=18)			FY1994	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
REVENUE (Annual Percent Change)											
Medicare	Total	Baseline		0.88%	0.54%	4.22%	4.42%	4.62%	4.33%	4.23%	4.13%
		With BBA					-0.51%	2.73%	2.56%	3.00%	2.99%
PROFIT MARGINS											
Medicare	Total	Baseline	-11.54%	-16.33%	-9.22%	-6.90%	-4.43%	-1.81%	0.46%	2.59%	4.58%
		With BBA					-9.60%	-8.82%	-8.23%	-7.18%	-6.15%
	Weighted Average	Baseline	-13.89%	-20.47%	-11.61%	-9.24%	-6.70%	-4.03%	-1.71%	0.46%	2.50%
		With BBA					-11.97%	-11.15%	-10.54%	-9.46%	-8.40%
All Payers	Total	Baseline	-3.58%	-9.34%	-6.70%	-5.31%	-3.81%	-2.18%	-0.75%	0.62%	1.92%
		With BBA					-6.92%	-6.46%	-6.11%	-5.48%	-4.86%
	Weighted Average	Baseline	-4.53%	-10.76%	-8.25%	-6.87%	-5.36%	-3.74%	-2.32%	-0.96%	0.34%
		With BBA					-8.49%	-8.05%	-7.71%	-7.10%	-6.48%

HOSPITALS WITH BETWEEN 100-200 BEDS (N=25)			FY1994	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
REVENUE (Annual Percent Change)											
Medicare	Total	Baseline		2.28%	-0.72%	4.20%	4.40%	4.60%	4.31%	4.21%	4.11%
		With BBA					-0.54%	2.81%	2.63%	3.08%	2.99%
PROFIT MARGINS											
Medicare	Total	Baseline	-8.22%	-10.22%	-9.28%	-6.98%	-4.52%	-1.92%	0.34%	2.45%	4.43%
		With BBA					-9.71%	-8.84%	-8.17%	-7.05%	-6.02%
	Weighted Average	Baseline	-10.12%	-12.47%	-11.46%	-9.11%	-6.60%	-3.95%	-1.65%	0.51%	2.53%
		With BBA					-11.91%	-11.03%	-10.35%	-9.21%	-8.17%
All Payers	Total	Baseline	-3.92%	-4.75%	-5.18%	-3.93%	-2.57%	-1.10%	0.20%	1.44%	2.62%
		With BBA					-5.41%	-4.95%	-4.58%	-3.97%	-3.40%
	Weighted Average	Baseline	-4.78%	-5.82%	-6.13%	-4.88%	-3.52%	-2.05%	-0.75%	0.49%	1.67%
		With BBA					-6.35%	-5.89%	-5.52%	-4.90%	-4.34%

HOSPITALS WITH MORE THAN 200 BEDS (N=31)			FY1994	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002
REVENUE (Annual Percent Change)											
Medicare	Total	Baseline		5.60%	3.08%	4.24%	4.42%	4.62%	4.33%	4.23%	4.13%
		With BBA					-2.15%	1.09%	0.99%	1.41%	2.50%
PROFIT MARGINS											
Medicare	Total	Baseline	3.16%	2.00%	5.59%	7.62%	9.76%	12.02%	13.98%	15.82%	17.55%
		With BBA					3.69%	2.82%	1.85%	1.27%	1.75%
	Weighted Average	Baseline	1.55%	0.08%	3.38%	5.46%	7.64%	9.96%	11.96%	13.84%	15.61%
		With BBA					1.52%	0.73%	-0.19%	-0.72%	-0.22%
All Payers	Total	Baseline	8.47%	5.09%	5.71%	6.71%	7.80%	8.97%	10.01%	11.01%	11.97%
		With BBA					4.79%	4.38%	3.92%	3.65%	3.87%
	Weighted Average	Baseline	7.56%	4.40%	4.73%	5.75%	6.84%	8.03%	9.08%	10.08%	11.04%
		With BBA					3.82%	3.44%	3.00%	2.74%	2.98%

Source: *Division of Health Care Finance and Policy*

Table B6

Massachusetts Acute Care Hospital Characteristics: 1996

HOSPITAL NAME	NUMBER OF BEDS	NUMBER OF MEDICARE DISCHARGES	SHARE OF MEDICARE DISCHARGES	IME PAYMENTS	DSH PAYMENTS	HOSPITAL-BASED TCU
ADDISON GILBERT HOSPITAL	70	1,803	62%	N	N	N
ANNA JAQUES HOSPITAL	114	3,006	41%	N	Y	Y
ATHOL MEMORIAL HOSPITAL	46	1,100	61%	N	N	N
ATLANTICARE MEDICAL CENTER	216	4,267	62%	Y	Y	Y
BAYSTATE MEDICAL CENTER	573	8,878	28%	Y	Y	N
BERKSHIRE MEDICAL CENTER	222	4,416	46%	Y	N	Y
BETH ISRAEL HOSPITAL	391	8,467	29%	Y	Y	N
BEVERLY HOSPITAL	224	4,978	32%	Y	N	Y
BOSTON MED. CTR. (BOSTON CITY HOSP.)	296	1,907	14%	Y	Y	N
BOSTON MED. CTR. (BOSTON UNIV. MED. CTR.)	233	4,620	49%	Y	Y	Y
BOSTON REGIONAL MEDICAL CENTER	156	2,319	29%	N	Y	N
BRIGHAM & WOMEN'S HOSPITAL	717	8,009	23%	Y	Y	N
BROCKTON HOSPITAL	237	4,257	41%	Y	Y	N
CAPE COD HOSPITAL	228	7,346	54%	Y	N	N
CARNEY HOSPITAL	243	4,550	56%	Y	Y	Y
CHARLTON MEMORIAL HOSPITAL	300	7,179	47%	N	Y	Y
CLINTON HOSPITAL	29	1,045	59%	N	N	N
COOLEY DICKINSON HOSPITAL	134	3,162	41%	N	N	N
DEACONESS GLOVER HOSPITAL	58	1,654	52%	Y	N	N
DEACONESS WALTHAM HOSPITAL	183	3,587	49%	Y	N	Y
EMERSON HOSPITAL	136	2,847	30%	N	N	Y
FAIRVIEW HOSPITAL	38	725	52%	N	N	N
FALMOUTH HOSPITAL	110	2,668	50%	N	N	N
FAULKNER HOSPITAL	151	2,989	49%	Y	N	N
FRANKLIN MEDICAL CENTER	82	1,998	45%	N	N	N
GOOD SAMARITAN MEDICAL CENTER	218	5,351	62%	Y	Y	N
HARRINGTON HOSPITAL	100	1,694	42%	Y	Y	N
HAVERHILL/HALE HOSPITAL	138	3,003	53%	N	N	N
HEALTHALLIANCE (BURBANK HOSPITAL)	117	2,052	58%	Y	N	N
HEALTHALLIANCE (LEOMINSTER HOSPITAL)	87	1,216	40%	Y	Y	N
HENRY HEYWOOD MEMORIAL HOSPITAL	95	2,036	48%	N	N	Y
HILLCREST HOSPITAL	116	1,128	56%	N	Y	N
HOLY FAMILY HOSPITAL	201	3,783	41%	N	N	N
HUBBARD REGIONAL HOSPITAL	34	753	57%	N	N	N
JORDAN HOSPITAL	123	3,262	45%	N	N	Y
LAHEY CLINIC HOSPITAL	282	6,559	47%	Y	N	N
LAWRENCE GENERAL HOSPITAL	230	3,606	35%	Y	Y	N
LAWRENCE MEMORIAL HOSPITAL	132	4,369	77%	Y	N	Y
LOWELL GENERAL HOSPITAL	166	3,287	28%	N	Y	Y
MALDEN HOSPITAL	91	3,012	51%	Y	Y	Y
MARLBOROUGH HOSPITAL	79	1,632	55%	Y	N	N
MARY LANE HOSPITAL	35	718	42%	N	N	N
MASS. EYE AND EAR INFIRMARY	53	505	29%	Y	N	N
MASS. GENERAL HOSPITAL	863	17,497	48%	Y	Y	N
MEDICAL CENTER OF CENTRAL MASS	418	7,394	35%	Y	Y	Y
MELROSE-WAKEFIELD HOSPITAL	185	5,085	47%	N	N	Y
MERCY HOSPITAL	252	5,030	64%	N	N	N
METROWEST MEDICAL CENTER	404	6,452	34%	Y	N	Y
MILFORD-WHITINSVILLE REGIONAL HOSP.	125	2,424	42%	Y	N	N
MILTON HOSPITAL	117	3,458	73%	N	N	Y
MORTON HOSPITAL AND MEDICAL CTR.	178	2,823	46%	N	Y	N
MOUNT AUBURN HOSPITAL	204	4,466	42%	Y	N	N
NANTUCKET COTTAGE HOSPITAL	22	301	44%	N	N	N
NEW ENGLAND BAPTIST HOSPITAL	141	3,127	54%	Y	N	Y
NEW ENGLAND DEACONESS HOSPITAL	312	5,360	48%	Y	N	Y
NEW ENGLAND MEDICAL CENTER	403	4,465	27%	Y	Y	Y
NEWTON-WELLESLEY HOSPITAL	221	3,834	25%	Y	N	N
NOBLE HOSPITAL	62	1,560	66%	N	N	N
NORTH ADAMS REGIONAL HOSPITAL	96	2,888	54%	N	N	Y
NORWOOD HOSPITAL	177	3,240	37%	N	N	Y
PROVIDENCE HOSPITAL	140	1,367	25%	Y	N	N
QUINCY HOSPITAL	254	4,810	53%	N	N	Y
SAINT VINCENT	318	8,882	47%	Y	N	N
SAINTS MEMORIAL MEDICAL CENTER	375	4,030	55%	N	Y	N
SALEM HOSPITAL	271	5,082	38%	Y	Y	N
ST. ANNE'S HOSPITAL	165	2,701	56%	Y	Y	N
ST. ELIZABETH'S MEDICAL CENTER	280	6,016	40%	Y	Y	N
ST. LUKE'S HOSPITAL	364	8,092	48%	N	Y	Y

HOSPITAL NAME	NUMBER OF BEDS	NUMBER OF MEDICARE DISCHARGES	SHARE OF MEDICARE DISCHARGES	IME PAYMENTS	DSH PAYMENTS	HOSPITAL BASED TCU
STURDY MEMORIAL HOSPITAL	179	2,222	40%	N	N	N
TOBEY HOSPITAL	60	1,927	59%	N	N	N
UNIV. OF MASS. MEDICAL CENTER	308	5,289	32%	Y	Y	N
WHIDDEN MEMORIAL HOSPITAL	113	3,273	71%	N	N	Y
WINCHESTER HOSPITAL	169	3,042	31%	Y	N	Y
WING MEMORIAL HOSPITAL	32	1,120	60%	N	N	N
TOTAL	14,692	283,001	46%			

Source: *Division of Health Care Finance and Policy*